

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4905 CERTIFICATE OF DEATH

04896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 12 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 Clyde Ave		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural-Fruitland) d. STREET ADDRESS 118 Clyde Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HAZEL First RUTH Middle BOZMAN Last		4. DATE OF DEATH Month APRIL Day 26th Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1903
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 2 Days 09	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee - Shirt Factory		10b. KIND OF BUSINESS OR INDUSTRY Somerset Co. Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James W. Warwick		14. MOTHER'S MAIDEN NAME Beulah Dodson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Evelyn Wallace (Daughter)		Address 118 Clyde Ave Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1953 to April 1959 , that I last saw the deceased alive on April 26, 1959 , and that death occurred at 7:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Alberta Mattax		DATE SIGNED Apr. 28 / 1959	
PHYSICIAN'S NAME (Type) Dr. Alberta Mattax		ADDRESS Camden Ave. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 28, 1959	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR MAY 1 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1908

1908

Form with multiple lines for text entry, including fields for name, date, and other vital statistics data.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4907

Item 7 Film 6242 5-20-59 et

CERTIFICATE OF DEATH

04897

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>Accomac</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>RURAL</u> <u>New Church</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA (GENERAL) HOSPITAL</u>				d. STREET ADDRESS <u>83X-3</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Perry</u> Middle <u>ALFRED</u> Last <u>BRIMER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7th</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/21/1895</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MAKEMIE PARK U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ALFRED</u>	
14. MOTHER'S MAIDEN NAME <u>BRIMER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>228-48-5292</u>		INFORMANT <u>Louis Leonard New Church</u> Address <u>New Church</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion, Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Lung</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>			
21. I certify that I attended the deceased from <u>April 5</u> , 19 <u>59</u> , to <u>April 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 7</u> , 19 <u>59</u> , and that death occurred at <u>10:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>PINEBLUFF Rd</u> DATE SIGNED <u>4/9/59</u>							
ACTUAL SIGNATURE <u>Rufus S. Gardner</u> M.D. <u>PINEBLUFF Rd</u>							
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u> <u>SALISBURY, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>4/8/59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>DOWNINGS</u>				22d. LOCATION (City, town, or county) (State) <u>OAK HALL VA.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>For FUNERAL Home</u> ADDRESS <u>TEMPERANCE VILLE VA.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 17 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4908

CERTIFICATE OF DEATH

04898

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle H. Last Bromwell		4. DATE OF DEATH Month April Day 17 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/1881
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired) SEAFOOD		10b. KIND OF BUSINESS OR INDUSTRY ?	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bromwell		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Hospital Records		Address _____	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) ?			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from March 16 , 19 59 , to April 17 , 19 59 , that I last saw the deceased alive on April 17 , 19 59 , and that death occurred at 3:48 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>L. V. Maldve</i>		ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 4/17/59	
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		22b. DATE THEREOF APRIL 20 1959	22c. NAME OF CEMETERY OR CREMATORY EAST NEW MARKET CEM.
22d. LOCATION (City, town, or county) EAST NEW MARKET		(State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FURNAL SERVICE		ADDRESS CAMBRIDGE MARYLAND.	
24a. REC'D BY REGISTRAR DATE APR 22 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>	

04899

4909

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Infant</u> <u>Son</u> <u>Burton</u>				4. DATE OF DEATH Month Day Year <u>APRIL</u> <u>19</u> <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/17/59</u>	
9. AGE (In years last birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>33</u> Min. <u>hrs</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>			
13. FATHER'S NAME <u>O.J. Burton</u>				14. MOTHER'S MAIDEN NAME <u>Lillianne Dickson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>---</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr. O.J. Burton, Same</u>				Address <u>---</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emboli (Post Exchange Transfusion)</u> 770.0 DUE TO <u>Hemolytic Disease of Newborn due to Rh factor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>---</u> DUE TO <u>---</u> (c) <u>---</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/17</u> , 19 <u>59</u> , to <u>4/19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/19/59</u> , 19 <u>59</u> , and that death occurred at <u>11:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred C. Kells</u> M.D. <u>Salisbury, Maryland</u>				DATE SIGNED <u>4/19/59</u>			
PHYSICIAN'S NAME (Type) <u>Alfred C. Kells</u>				<u>411 West College Ave., Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>J. William Lee's Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR <u>APR 23 '59</u>			
ADDRESS <u>---</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Brand</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082284XV2 may D Baker

1930

THE DEATH OF DEATH

1930



1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930



4910

CERTIFICATE OF DEATH

04900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXXXXXXX Salisbury		c. LENGTH OF STAY IN 1b 6 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 810 East Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas E. Butler		4. DATE OF DEATH Month 4 Day 8 Year 19 59	
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8- 14- 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Clergical	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William E. Butler		14. MOTHER'S MAIDEN NAME Alice Nickles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215 12 2175	
17. INFORMANT Mrs. Thomas Butler, 810 East Rd., Salisbury, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio- (c) sclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 months Stroke	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-7-59 to 8-9-59 , that I last saw the deceased alive on 8-6-59 , 19 59 , and that death occurred at 10:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. A. Purnell		ADDRESS (Street, city or town, state) 622 N. Main DATE SIGNED 10-9-59	
PHYSICIAN'S NAME (Type) E. A. Purnell, M. D.		Salisbury, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/11/1959	22c. NAME OF CEMETERY OR CREMATORY Federal Hill	22d. LOCATION (City, town, or county) (State) Federalburg, Md
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Stewart Funeral Home, Salisbury, Md		24a. REC'D BY REGISTRAR DATE APR 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE

11/11

Form with multiple horizontal lines for text entry, including fields for name, date, and other details. The form is mostly blank with some faint markings.

11/11



11/11



4911

CERTIFICATE OF DEATH

04901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				/d STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Briscoe</u> Last <u>G. S. Y.</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/13/1901</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>7</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boat Railway</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Briscoe</u>				14. MOTHER'S MAIDEN NAME <u>Annie Murray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Mrs Howard Gordy, Sr., Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY INSUFFICIENCY</u> DUE TO (c) <u>ATHEROSCLEROSIS</u>						<u>2 HOURS</u> <u>4 YEARS</u> <u>4 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>5 MAY 1947</u> to <u>20 APRIL 1959</u> , that I last saw the deceased alive on <u>20 APRIL 1959</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.				ADDRESS (Street, city or town, state) <u>Nanticoke, Md.</u> DATE SIGNED <u>4/22/59</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>				<u>Nanticoke, Maryland</u> <u>4/22/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Turners Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Nanticoke, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Bivale</u> ADDRESS <u>Bivale, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>APR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

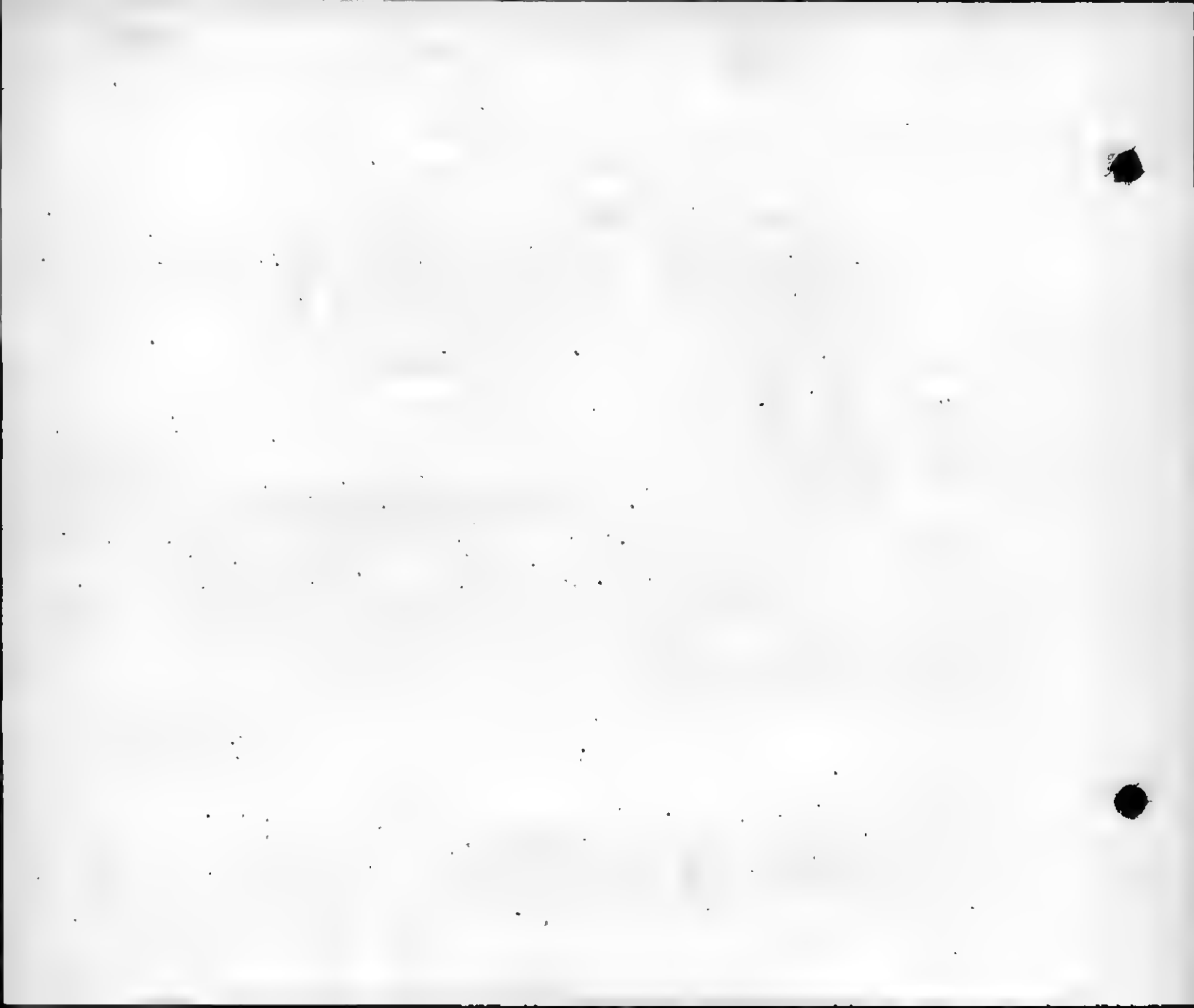
4912

CERTIFICATE OF DEATH

04902

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>N. MAIN ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>ALONZO</u> Middle <u>P.</u> Last <u>CHRISTOPHER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 18, 1883</u> 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MAYOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u>	
11. BIRTHPLACE (State or foreign country) <u>DENTON MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN J. CHRISTOPHER</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE TOWERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs. A. P. CHRISTOPHER BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO <u>Acute Posterior Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO <u>Arteriosclerosis Cardiovascular Dis.</u> (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/25</u> , 19 <u>59</u> , to <u>4/25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/25</u> , 19 <u>59</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner</u> M.D.		ADDRESS (Street, city, or town, State) <u>PINEBLUFF RD</u> DATE SIGNED <u>4/25/59</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR. SALISBURY, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burboye</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 29 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

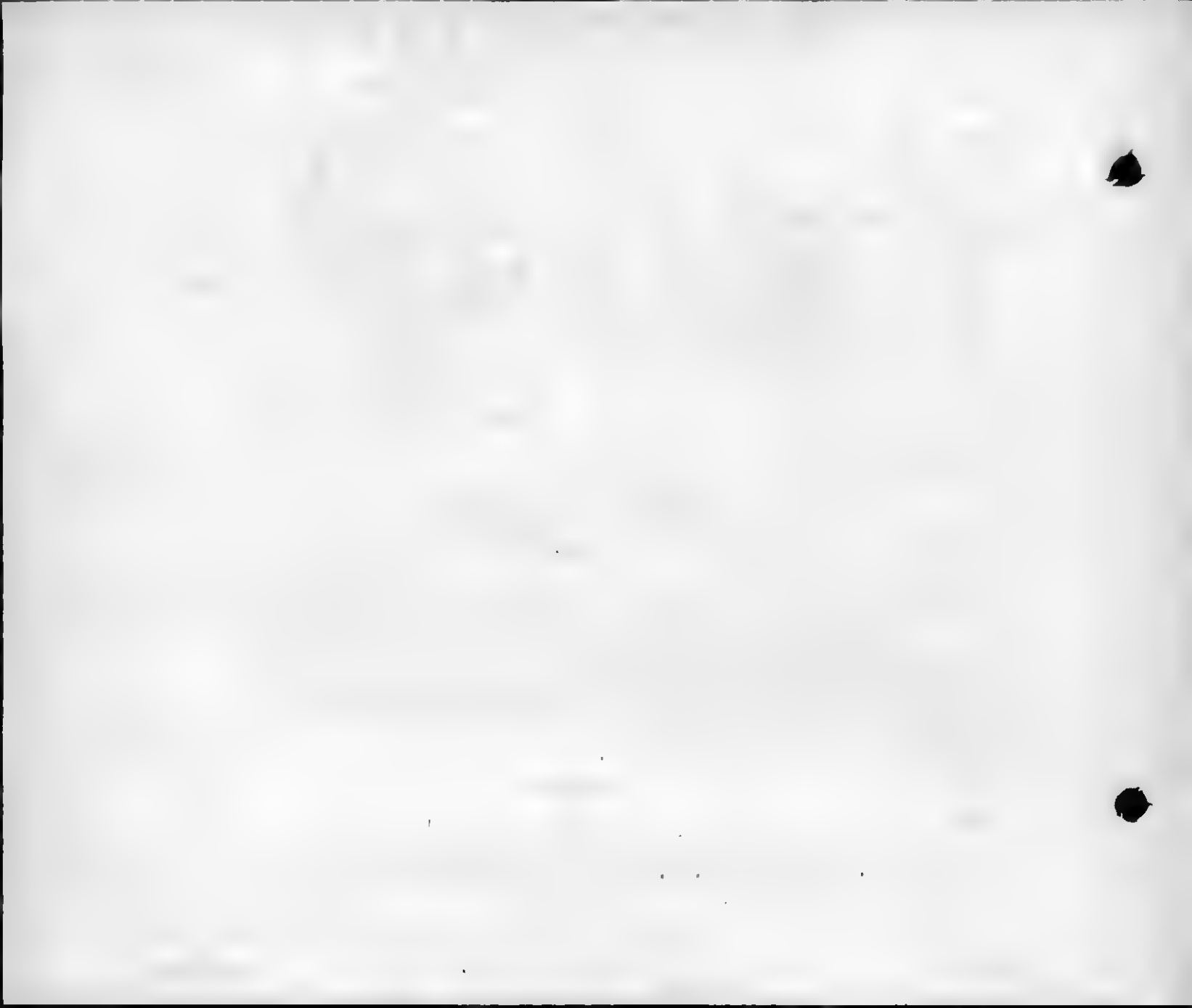
4913

CERTIFICATE OF DEATH

Reg. Dist. No. 04903

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 39 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. STREET ADDRESS Pittsville	
3. NAME OF DECEASED (Type or print) First Pauline Middle Gladys Last Cooper		4. DATE OF DEATH Month April Day 6 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/28/1918
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Dennis		14. MOTHER'S MAIDEN NAME Myra Disharoon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. 212-14-4242	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abscess of right lung 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic pneumonitis DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma			INTERVAL BETWEEN ONSET AND DEATH ? ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb. 26, 1959 , to April 6, 1959 , that I last saw the deceased alive on April 6, 1959 , and that death occurred at 7:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L. V. Maldve		ADDRESS (Street, city or town, state) DATE SIGNED Deer's Head State Hospital 4/6/59	
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		Salisbury, Maryland	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/11/59	22c. NAME OF CEMETERY OR CREMATORY Green Hope	22d. LOCATION (City, town, or county) (State) Salisbury, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Hakey, Salisbury, Md.		24a. REC'D BY REGISTRAR DATE APR 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur H. Hakey			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury md</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>G.S. Hospital</u>		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Tyrone</u> First <u>Cattmon</u> Middle Last		4. DATE OF DEATH Month <u>4</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-19-56</u>
9. AGE (In years last birthday) <u>2</u> yrs		10. IF UNDER 1 YEAR Months <u>11</u> Days	11. IF UNDER 24 HRS Hours <u></u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>G.S. Hospital</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Cattmon</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Cattmon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mildred Cattmon</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>toxic pneumonia</u> 4-22-59 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. (c) <u></u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip A. Insley</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Philip A. Insley</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL, SPECIFY <u>Burial</u>		22b. DATE THEREOF <u>4-27-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Wicomico md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Boaker H. Crest</u> ADDRESS <u></u>		24a. REC'D BY REGISTRAR DATE <u>MAY 5 1959</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thrall</u>	

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4915

CERTIFICATE OF DEATH

04905
 Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>Edgewater Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Herbert Joseph Cropper</u>		4. DATE OF DEATH Month Day Year <u>April 14 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1924</u>
9. AGE (In years last birthday) <u>34</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EMPLOYEE (U.S.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. P. OFFICE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GRANVILLE CROPPER JR.</u>		14. MOTHER'S MAIDEN NAME <u>ANNA HUDSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>MR. GRANVILLE CROPPER JR. Ocean City Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breast Tumor</u> <u>237X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-12</u> , 1959, to <u>4-14</u> , 1959, that I last saw the deceased alive on <u>4-14</u> , 1959, and that death occurred at <u>6:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard S. Elin</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>4-16-59</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS</u>	22d. LOCATION (City, town, or county) (State) <u>BISHOPVILLE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbo</u>		ADDRESS <u>Berlin Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles A. Thomas</u>	



4916

CERTIFICATE OF DEATH

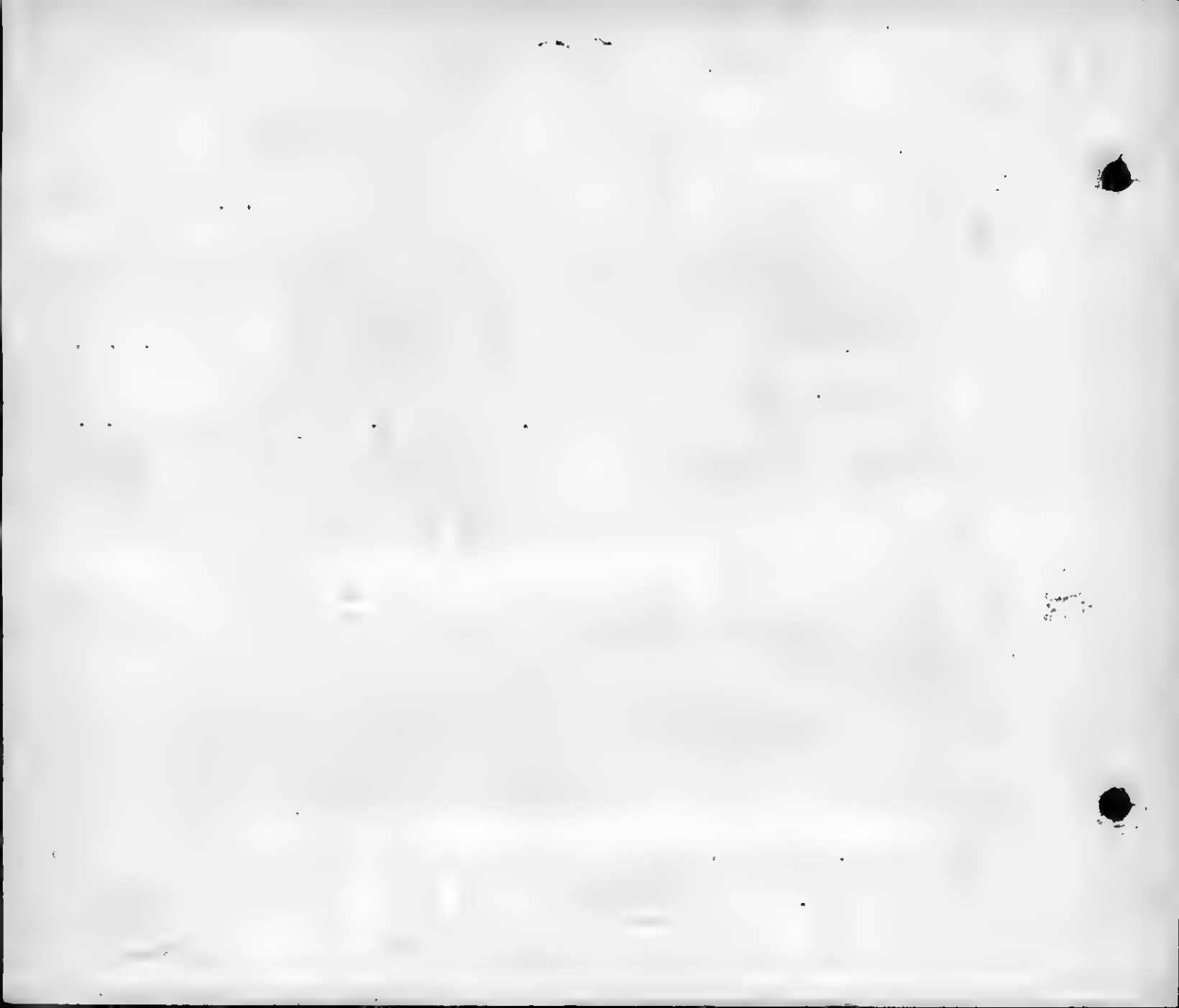
04895

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b three days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Deer's Head State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)			
f. STREET ADDRESS Dagsboro Road (R.D.# 3)				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Martha Middle Kissam Last Bellows		4. DATE OF DEATH Month April Day 3 Year 19 59		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 19, 1862		9. AGE (In years last birthday) 97 yrs.		10. IF UNDER 1 YEAR Months 1 Days 14	
11. IF UNDER 24 HRS. Hours 14 Min. 14		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (House Work)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Jersey City New Jersey	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Thomas B. Kissam			
14. MOTHER'S MAIDEN NAME Martha Gillingham				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO Informant				17. ADDRESS Mrs. Adelaide K. Whipple (Daughter) R.D.#3 Hospital Records - Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic - Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - General DUE TO (c) Old Cerebral Thrombosis						INTERVAL BETWEEN ONSET AND DEATH Years 42.2 Years 42.2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/1/59 19__ to 4/3/59 19__, that I last saw the deceased alive on 4/3/59 19__, and that death occurred at 6:35 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Maldve				ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 4/4/59			
PHYSICIAN'S NAME (Type) L. Maldve, M.D.				Deer's Head State Hospital-Salisbury, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Apr. 5 /59		Wicomico Memorial Park		Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR APR 9 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04906

4917

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				c. LENGTH OF STAY IN 1b 10mo. 17 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oriole, Maryland				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Beulah Middle Cordellia Last Crosswell				4. DATE OF DEATH Month April Day 19 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 22, 1881	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Zadoc Phoebus				14. MOTHER'S MAIDEN NAME Roberta Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. unk		17. INFORMANT Hospital Records		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Hypertensive Arteriosclerotic Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 years DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2, 19 58 , to Apr. 19, 19 59 , that I last saw the deceased alive on Apr. 19, 19 59 , and that death occurred at 2:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 4/19/59							
ACTUAL SIGNATURE Dr. Juerman M.D.				PHYSICIAN'S NAME (Type) V. Juerman, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/22/59		22c. NAME OF CEMETERY OR CREMATORY Oriole		22d. LOCATION (City, town, or county) (State) Oriole, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James H. Heiman				ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR Apr 22 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04907

Reg. Dist. No.

4965

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Powellville</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Powellville (Rural)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D.# Pittsville</u>				d. STREET ADDRESS <u>R.D.# Pittsville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ALVIA</u> Middle <u>JEFFERSON</u> Last <u>DAVIS</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>25th</u> Year <u>19 59</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 22, 1903</u>		
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Powellville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Thomas Jefferson Davis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Martha Perdue</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO. 		17. INFORMANT <u>Mrs. Mary Martha Davis (Mother)</u> <u>Powellville</u> <u>(R.D.# Pittsville) Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of heart</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last. DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in chest.</u>					
20c. TIME OF INJURY Month, Day, Year <u>10 A</u> <u>4-25-59</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Own home.</u>		20f. (City or town) <u>Parsonsburg</u> (County) <u>Wicomico</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Earl L. Boyer</u> M.D. EXAMINER'S NAME (Type) <u>Dr. Earl L. Boyer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
DATE SIGNED <u>April 27 /1959</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 28, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Johns Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Powellville, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>MAY 1 '59</u>		
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Smith</u>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and page 1 must be filed within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

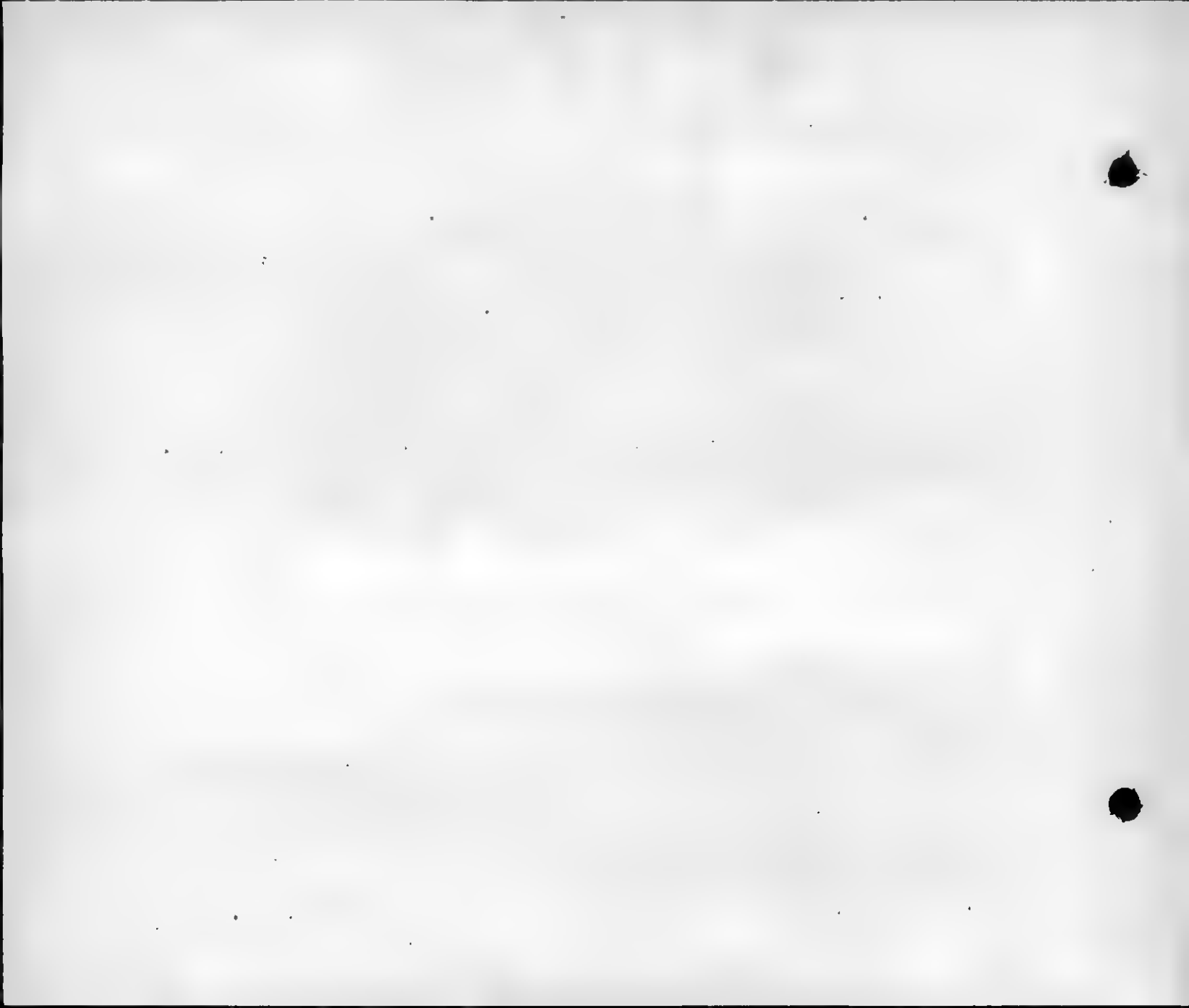
4966

CERTIFICATE OF DEATH

04908

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 W. State Street				d. STREET ADDRESS 8 W. State Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ernest Middle Del Last Davis				4. DATE OF DEATH Month April Day 12th Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 11, 1886		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John James Davis				14. MOTHER'S MAIDEN NAME Mary Emily Benson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 222-01-7549		17. INFORMANT Address Augusta Davis, Delmar, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Edema of Myocardial Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cardiac Parenchymal disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 46 , to Apr 12 , 19 59 , that I last saw the deceased alive on Apr 11 , 19 59 , and that death occurred at 4 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Delmar, Del DATE SIGNED _____ ACTUAL SIGNATURE S. H. Lynch PHYSICIAN'S NAME (Type) S. H. Lynch Delmar, Del.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-14-59		22c. NAME OF CEMETERY OR CREMATORY Melson		22d. LOCATION (City, town, or county) (State) Delmar, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Marvel Co. Delmar, Del.				24a. REC'D BY REGISTRAR DATE PR 1 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hunt	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4918

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

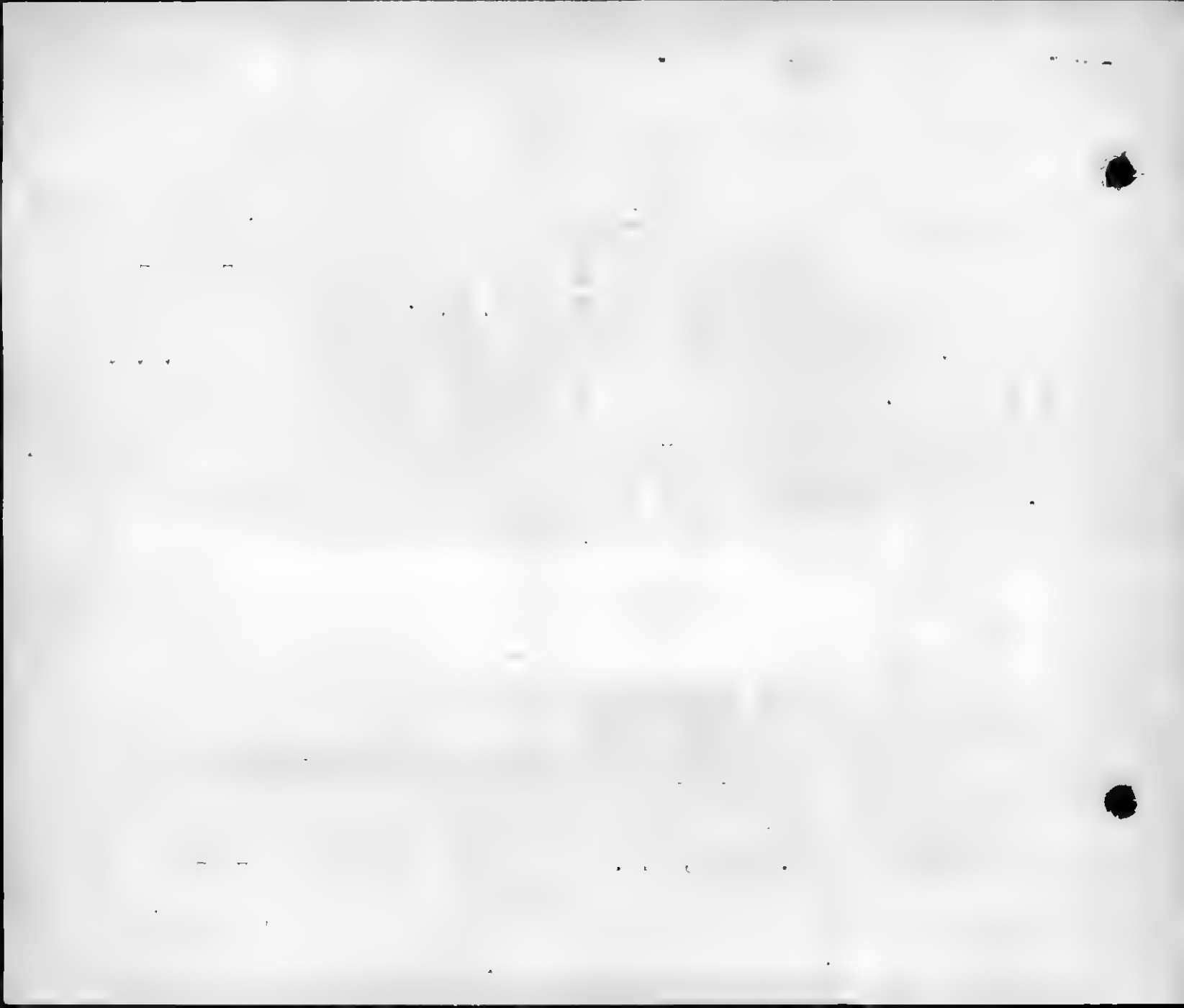
04909

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chincoteague</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>North Main Street</u>			
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>Derrickson</u> Middle Last				4. DATE OF DEATH <u>4-11-1959</u> Month Day Year			
5. SEX <u>WM</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 16, 1904</u>	
9. AGE (In years last birthday) <u>54</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Coast Guard</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank L. Derrickson</u>				14. MOTHER'S MAIDEN NAME <u>Emma Watson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes World War 2</u>				16. SOCIAL SECURITY NO. <u>227-34-3310</u>		17. INFORMANT <u>Bill Derrickson</u> Address <u>Chincoteague, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral edema</u>						<u>Sudden</u>	
DUE TO (b) <u>Acute alcoholism</u>						<u>Hours</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4-17-59</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 14, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Downing Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oak Hall, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Salyer</u> ADDRESS <u>Chincoteague, Va.</u>				24a. REC'D BY REGISTRAR <u>APR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4919

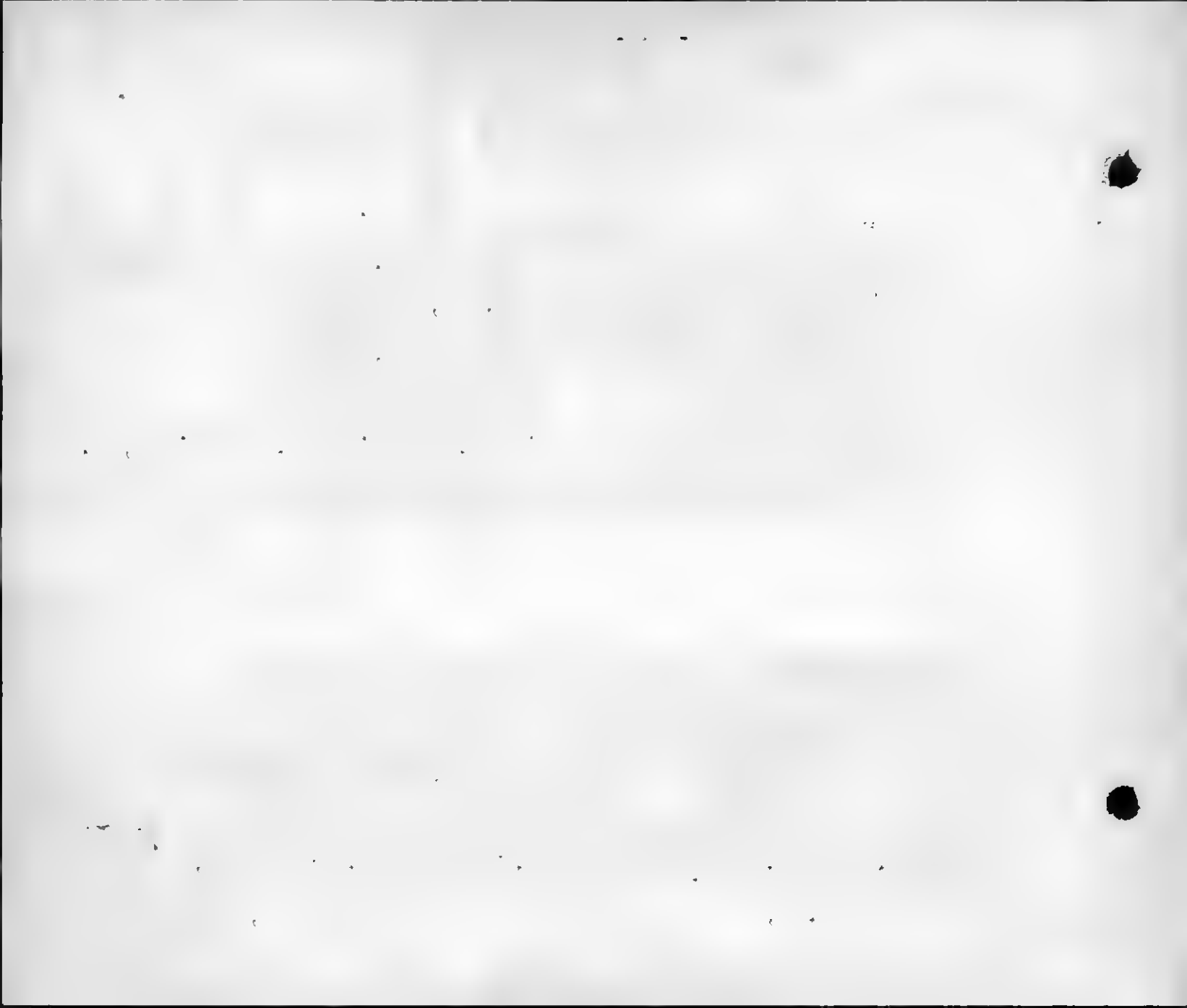
CERTIFICATE OF DEATH

04910

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		d. STREET ADDRESS 1101 N. Division St	
3. NAME OF DECEASED (Type or print) FREDERICK AUGUSTUS DISHAROON SR.		4. DATE OF DEATH APRIL 28th 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Mn.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter & Builder		10b. KIND OF BUSINESS OR INDUSTRY Pocomoke, Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME John Sidney Disharoon		14. MOTHER'S MAIDEN NAME Mary Ann Mason	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO Unk	
17. INFORMANT Mr. Frederick A. Disharoon Jr. (Son)		18. ADDRESS 1101 N. Division St. Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lympho Sarcoma of Mediastinum DUE TO 202.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 202.1 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Indurion	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o m p. m		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1951 to 4/30 1959 , that I last saw the deceased alive on 4/28 1959 , and that death occurred at 2:00 P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) S. Division St. Salisbury, Maryland	
ACTUAL SIGNATURE Fred R. Gramse		DATE SIGNED 4/29/59	
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse		S. Division St. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 30, 1959	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR MAY 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04911

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 842 W. Main St		d. STREET ADDRESS 842 W. Main St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First REBECCA Middle EMILY Last ELLIS		4. DATE OF DEATH Month APRIL Day 17th Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1866
9. AGE (In years last birthday) yrs. 92		IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Snow Hill, Maryland		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME Isaac Flemming		14. MOTHER'S MAIDEN NAME Rebecca (unk)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT	
17. ADDRESS Mrs. Nick Howard (Grand-Daughter) 842 W. Main St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion, acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary artery sclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 minutes 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 1951, to April , 1959, that I last saw the deceased alive on April 10 , 1959, and that death occurred at 6:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Camden Ave. Salisbury, Maryland DATE SIGNED Apr. 18 / 1959			
ACTUAL SIGNATURE Harry Mattax M.D.			
PHYSICIAN'S NAME (Type) Dr. Harry Mattax			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 20, 1959	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE APR 20 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4921

CERTIFICATE OF DEATH

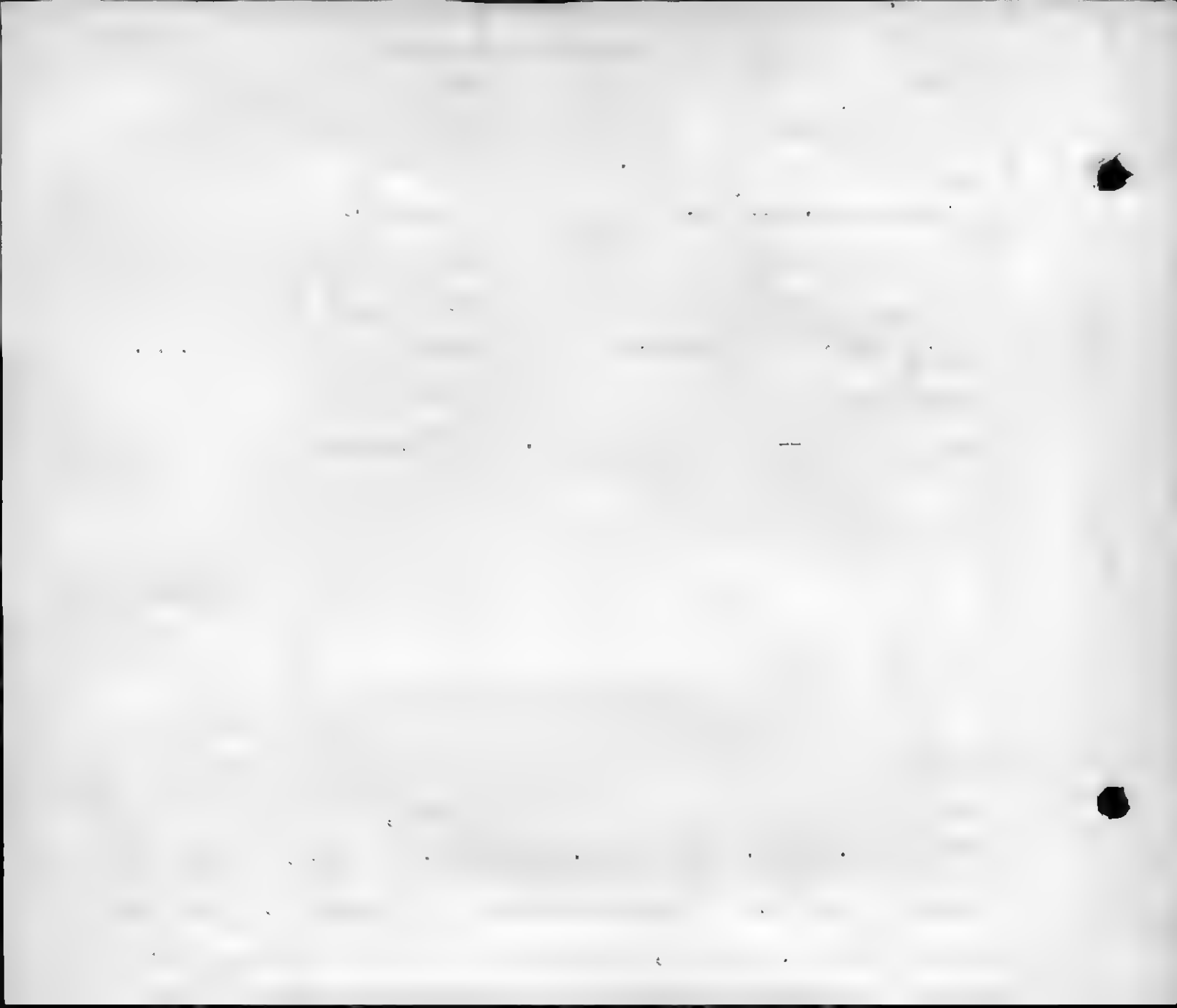
04912

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
c. LENGTH OF STAY IN 1b 4 Wks.				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Pr. Sanitorium			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				f. STREET ADDRESS Anderson Rd.,			
3. NAME OF DECEASED (Type or print)		First OLIN Middle THOMAS Last ELZEY		4. DATE OF DEATH Month 4 Day 22 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1879	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Elzey				14. MOTHER'S MAIDEN NAME Hester Bradley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Guy Elzey, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <input checked="" type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 6, 1959 to 7/24/59 , that I last saw the deceased alive on 7/24 , 19 59 , and that death occurred at 2:30 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 4/24/59							
ACTUAL SIGNATURE Fred R. Gramse		M.D. Salisbury, Maryland		DATE SIGNED 4/24/59			
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse 402 S. Division St., Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/59		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE APR 27 '59		24b. REGISTRAR'S SIGNATURE Norman T. Baker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 04913

4922

1 PLACE OF DEATH a. COUNTY <i>Wicomico</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i> c. LENGTH OF STAY IN 1b		2 USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <i>md</i> b. COUNTY <i>Wicomico</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury md</i> d. STREET ADDRESS <i>1511 Booth St</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>George</i> First Middle Last <i>FARLOW</i>		4. DATE OF DEATH <i>APRIL 9, 1959</i>	
5 SEX <i>MALE</i>	6. COLOR OF RACE <i>NEGRO</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>1908</i>
9. AGE (In years last birthday) <i>50</i>		10. IF UNDER 1 YEAR: Months <i>50</i> Days <i>50</i> Hours <i>50</i> Min <i>50</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Wicomico Co</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Farlow</i>		14. MOTHER'S MAIDEN NAME <i>Anna Postley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>WW II</i>		16. SOCIAL SECURITY NO. <i>?</i>	
17. INFORMANT <i>Mary Parsons</i>		Address <i>511 Booth St</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Degenerative cardiovascular disease</i> 4 0-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary arteriosclerosis</i> (c) <i>generalized arteriosclerosis</i> DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4-1-1959</i> to <i>4-9-1959</i> , that I last saw the deceased alive on <i>4-9-1959</i> , and that death occurred at <i>711 Camden Avenue</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Harry Nealey</i> M.D.		ADDRESS (Street, city or town, state) <i>711 Camden Avenue Salisbury, Md.</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>4-12-59</i>	<i>Pudeto Cem.</i>	<i>Wicomico md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Boaker McWest</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>APR 15 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Huns</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

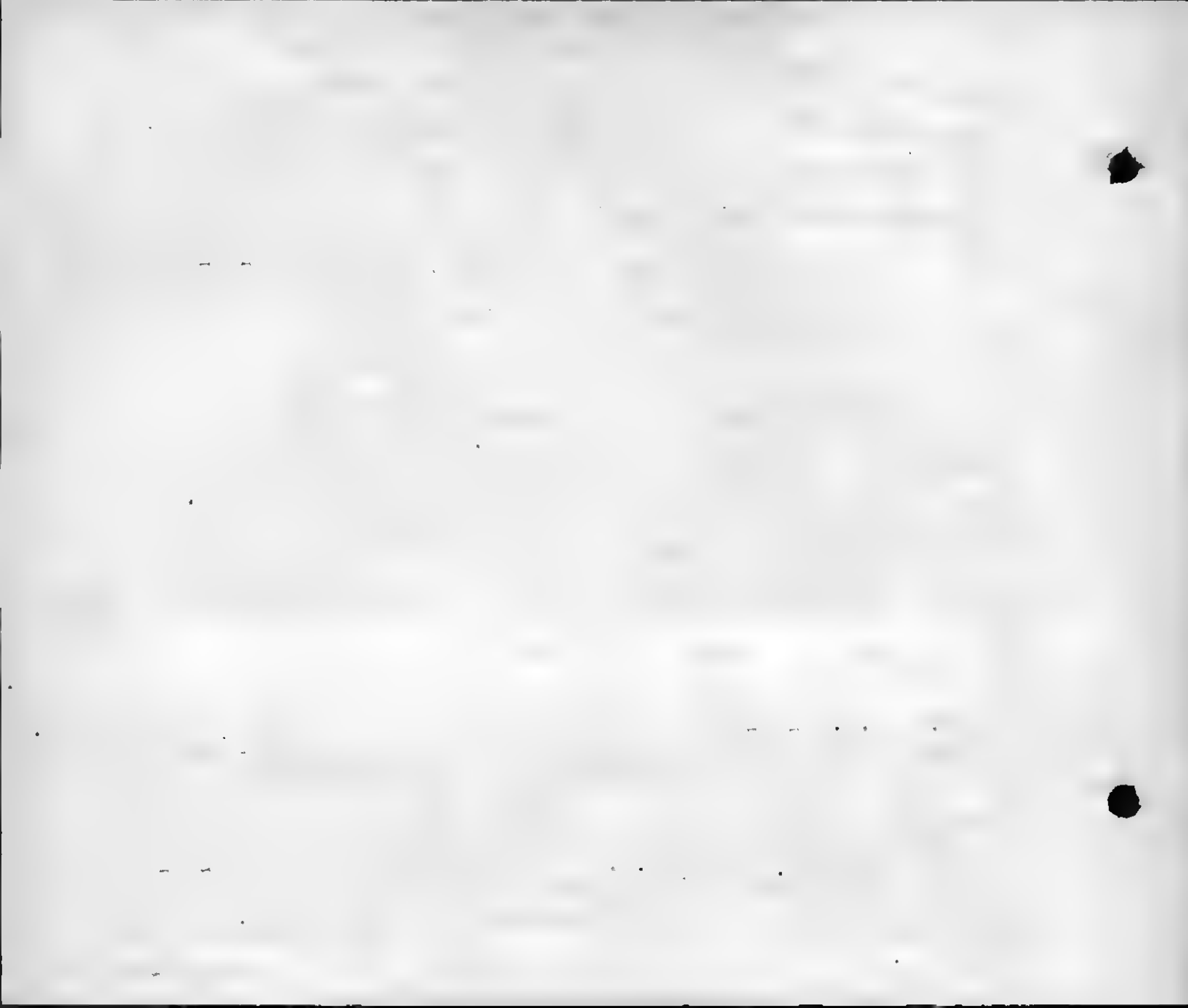
04914

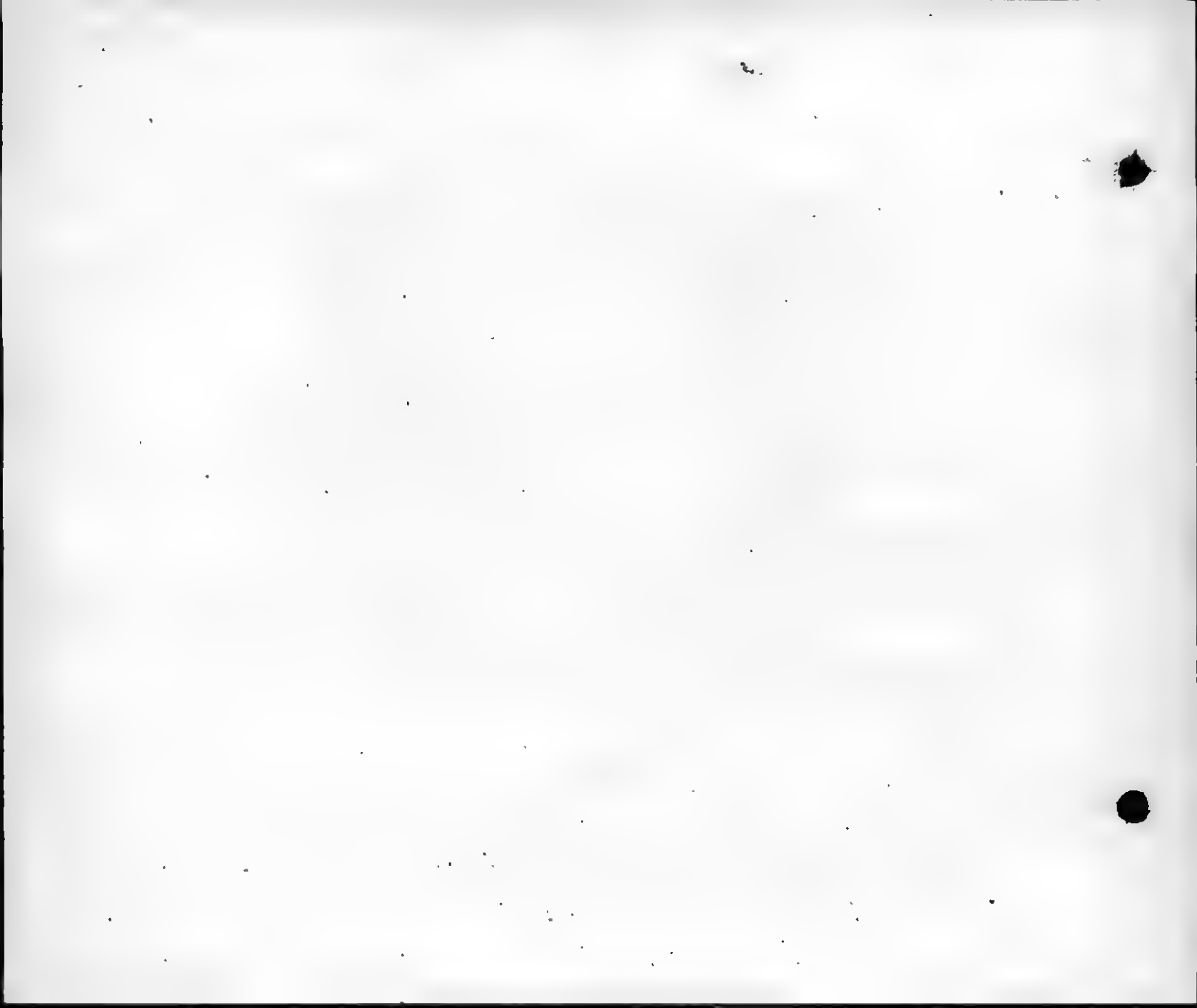
Reg. Dist. No.

1923

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Parsonsburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>L</u> Last <u>Foskey</u>				4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 9, 1896</u>		9. AGE (In years last birthday) <u>62</u> yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saw Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>			
13. FATHER'S NAME <u>Greensbury Foskey</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Mariner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>222-09-4691</u>		17. INFORMANT Address <u>Mary E. Foskey, RD, Millsboro, Delaware</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured cervical spine: crushed chest.</u> <u>823X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driving car that ran off road and turned over on him.</u>					
20c. TIME OF INJURY Month, Day, Year <u>12:15 p.m. A.M. 4-18-59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>			
20f. (City or town) <u>Salisbury</u>		20g. (County) <u>Wicomico</u>		20h. (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-23-59</u>			
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Laurel, Del.</u>		22e. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Address <u>Homer L. Disharoon, Laurel, Del.</u>			24a. REC'D BY REGISTRAR <u>APR 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04916

CERTIFICATE OF DEATH

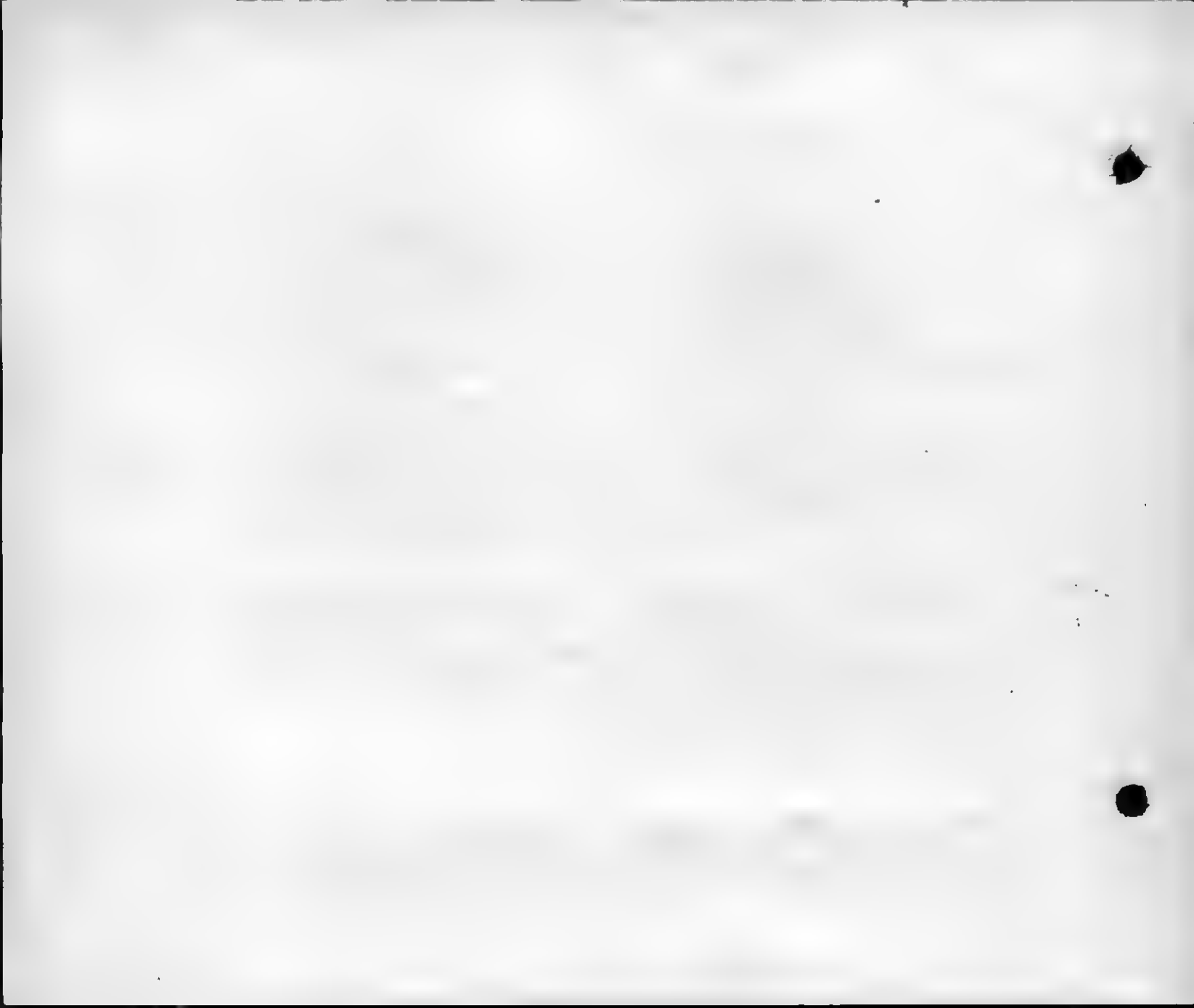
Reg. Dist. No.

4925

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Goodrich</u> Last <u>Goodrich</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1866 (?)</u>
9. AGE (In years last birthday) <u>93</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>John Goodrich</u>	
14. MOTHER'S MAIDEN NAME <u>Martha Sharpe (?)</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>Unk.</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u> </u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of colon</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 26</u> , 19 <u>54</u> , to <u>April 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 12</u> , 19 <u>59</u> , and that death occurred at <u>11:10 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>4/13/59</u>			
ACTUAL SIGNATURE <u>G. Kosmahly</u> M.D.		PHYSICIAN'S NAME (Type) <u>G. Kosmahly, M.D.</u> <u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oldfield</u>	22d. LOCATION (City, town, or county) (State) <u>Hughesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Brand</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

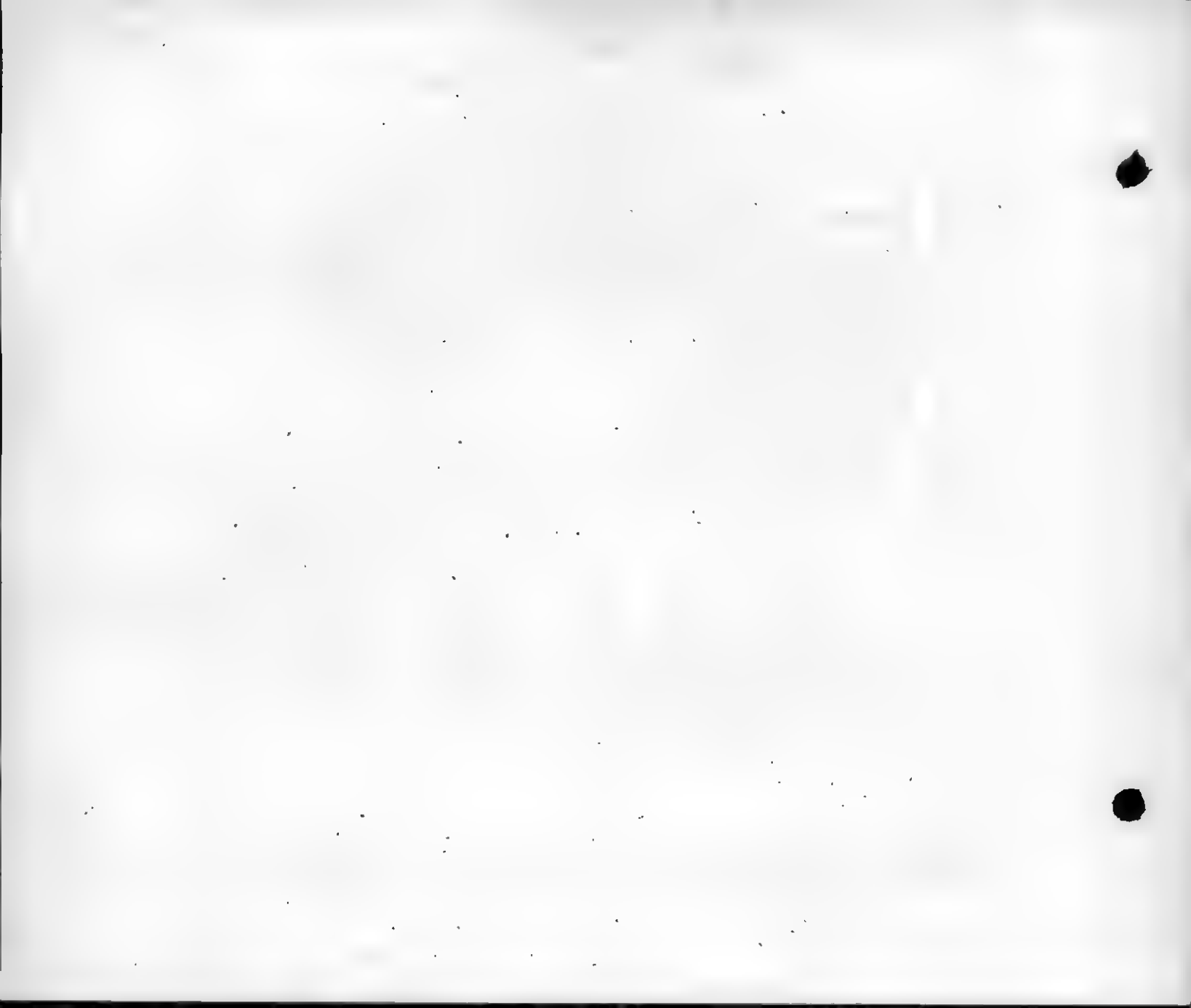


1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 17, Film G242, 5/6/59
4926
CERTIFICATE OF DEATH

04917
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shelton</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CALVIN D. Gumm</u>		4. DATE OF DEATH Month Day Year <u>APRIL 28 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1926</u>
9. AGE (In years last birthday) <u>73</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles F. Gumm</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Townsend</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(Yes, no, or unknown)</u>		16. SOCIAL SECURITY NO. <u>214-36-5115</u>	
17. INFORMANT <u>Mary</u> Address <u>rs 2217 GALT Stone 1, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure & Pulmonary Edema</u> DUE TO (b) <u>acute myocardial infarction</u> DUE TO (c) <u>Coronary Artery Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 27, 1959</u> to <u>April 28, 1959</u> that I last saw the deceased alive on <u>April 27, 1959</u> and that death occurred at <u>12:34 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hef, Jr. M.D.</u>		ADDRESS (Street, city or town, state) <u>Pine Bluff Road Salisbury, Md</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Md</u>		DATE SIGNED <u>4/28/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>I</u>		22b. DATE THEREOF <u>4/30/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Methoist church, York</u>		22d. LOCATION (City, town, or county) (State) <u>Frankford Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley</u>		ADDRESS <u>Salisbury, Md</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	



CERTIFICATE OF DEATH

04918

Reg. Dist. No.

4927

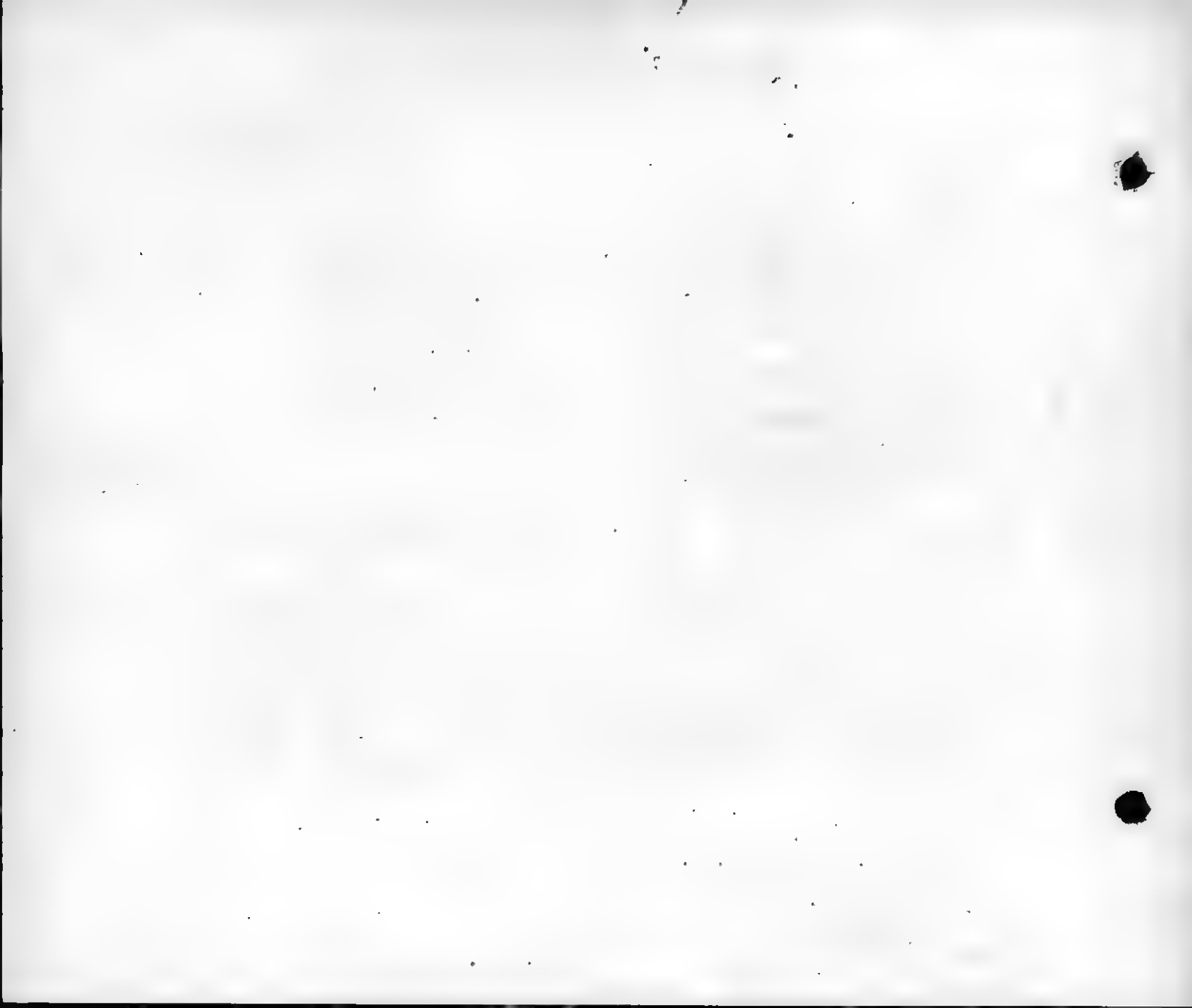
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ernest Middle J. Last Gunby				4. DATE OF DEATH Month April Day 22 Year 19 59			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. ? , 1888	
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?				10b. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Gunby				14. MOTHER'S MAIDEN NAME Amy Benson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.				16. SOCIAL SECURITY NO. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH 3 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from April 20 , 19 59 , to April 22 , 19 59 , that I last saw the deceased alive on April 22 , 19 59 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE V. Juerman				M.D. Deer's Head State Hospital 4/22/59			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Rem-Burial		22b. DATE THEREOF 4/28/1959		22c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery		22d. LOCAT ON (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard W. S. S. S.				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE APR 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hump			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

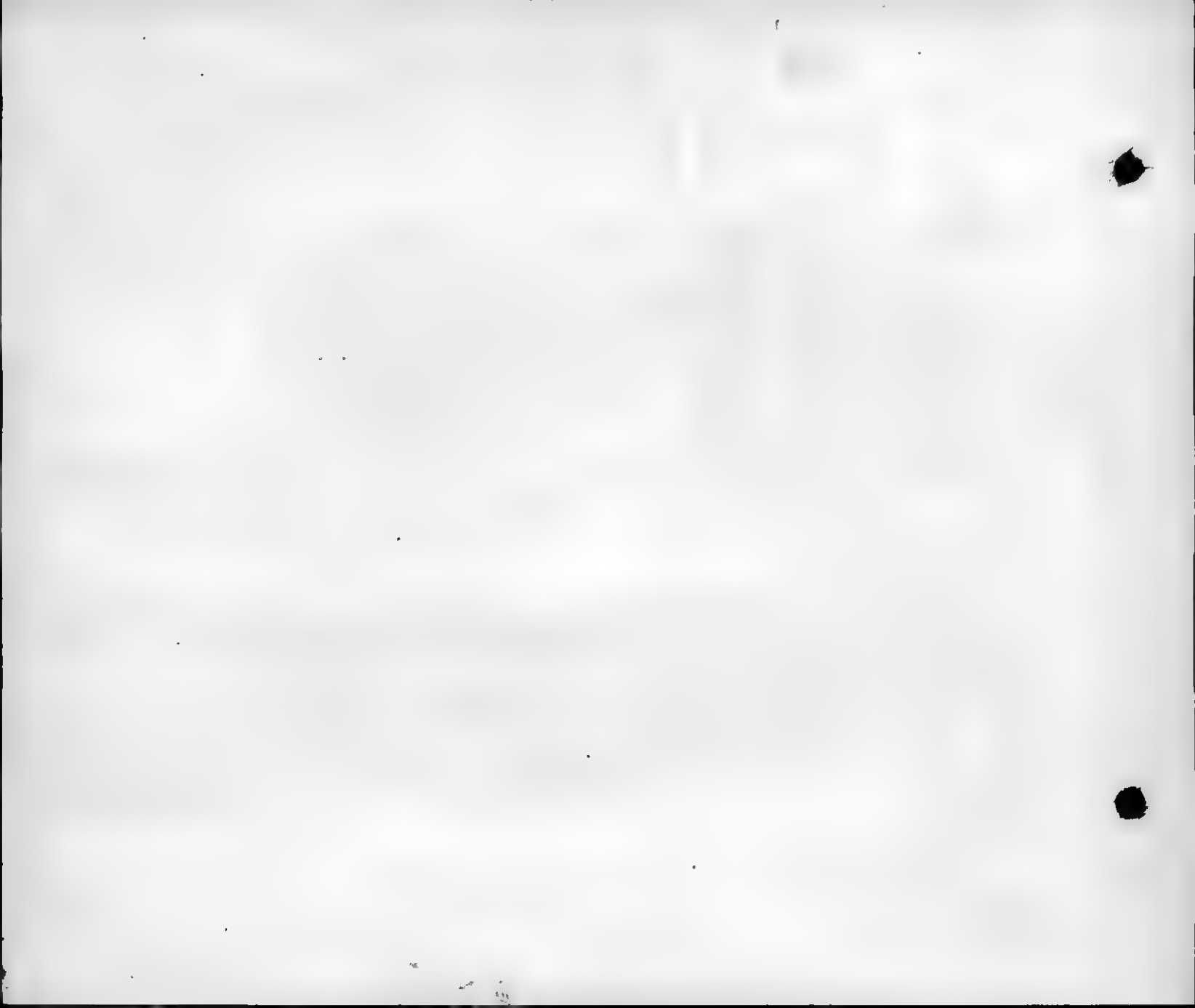
CERTIFICATE OF DEATH

04919

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 7½ yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. STREET ADDRESS 49 Upshur Street	
3. NAME OF DECEASED (Type or print) First Rose Middle Henson Last Henson		4. DATE OF DEATH Month April Day 2 Year 19 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? 1897
9. AGE (In years last birthday) 62 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Lloyd Henson		14. MOTHER'S MAIDEN NAME Laura Cazer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service Unk.		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) ? INTERVAL BETWEEN ONSET AND DEATH 4 minutes			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic adhesive arachnoiditis with quadriplegia; multiple decubiti. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 30 , 19 51 , to April 2 , 19 59 , that I last saw the deceased alive on April 2 , 19 59 , and that death occurred at 12:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 4/2/59			
ACTUAL SIGNATURE Dr. J. Juerman		M.D. Deer's Head State Hospital	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-8-59		22b. DATE THEREOF 4-8-59	
22c. NAME OF CEMETERY W. of Med. School		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE APR 10 59		Arthur L. H...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4929

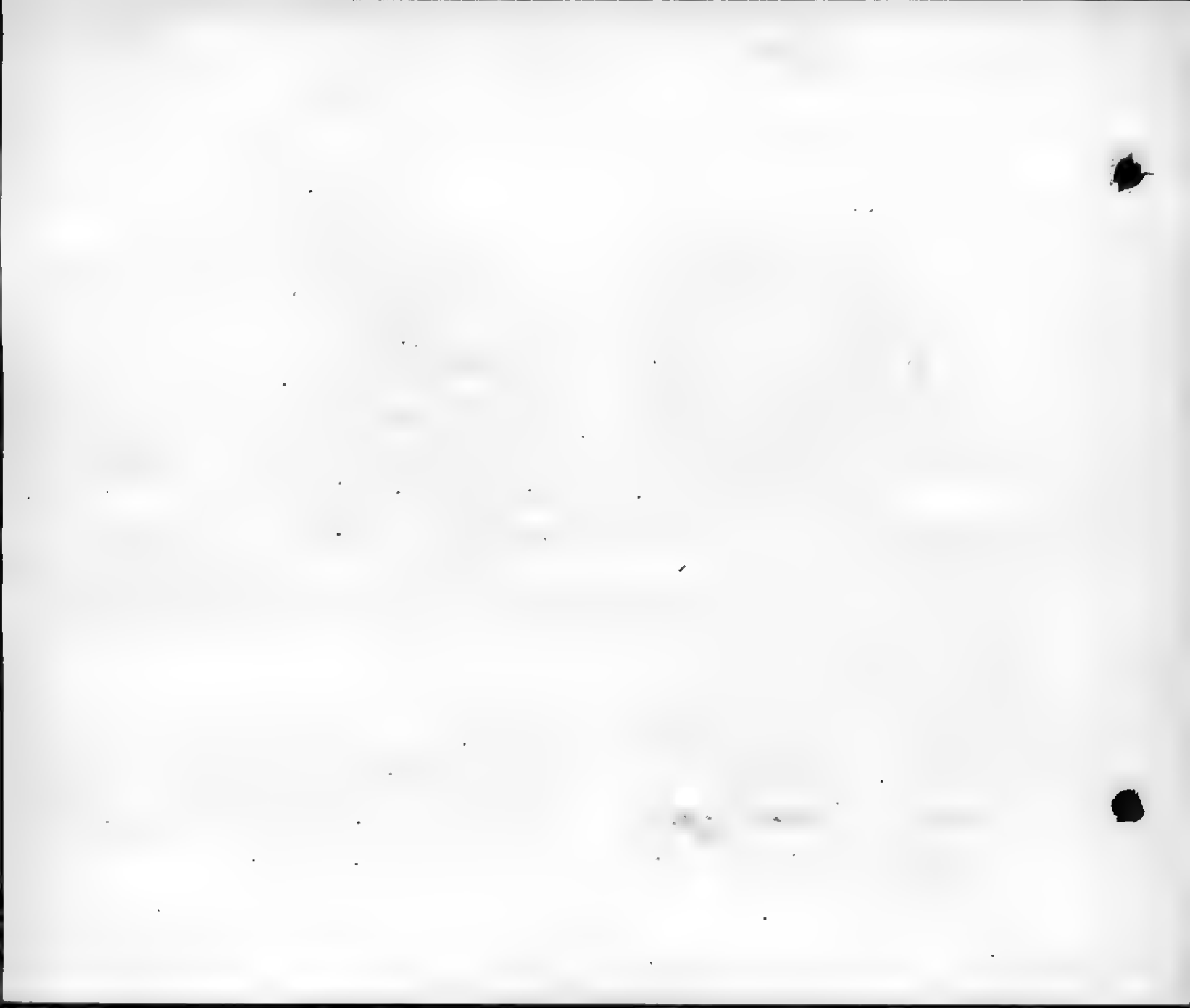
CERTIFICATE OF DEATH

04920

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 20 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Ingleside 17X- d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Medford Holden			4. DATE OF DEATH Month Day Year April 22 1959				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/1890	9. AGE (In years last birthday) yrs. 68	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Tenant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME William Holden			14. MOTHER'S MAIDEN NAME No Record				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 151-14-7903		INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Cerebral thrombosis with rt. hemiplegia and motor aphasia DUE TO (b) Hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 5 weeks Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from April 2 1959, to April 22 1959, that I last saw the deceased alive on April 22 1959, and that death occurred at 7:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 4/23/59							
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) G. Kosmahly, M.D. Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/25/59	22c. NAME OF CEMETERY OR CREMATORY Busic	22d. LOCATION (City, town, or county) (State) Barclay, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais			24a. REC'D BY REGISTRAR DATE APR 27 '59		24b. REGISTRAR'S SIGNATURE 		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04921

4930

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First John Middle Jackson Last Jackson		4. DATE OF DEATH Month April Day 13 Year 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1894
9. AGE (In years lost birthday) yrs. 64		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 023X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Luetic cardiovascular disease DUE TO (c) ?			INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right hemiplegia due to recurrent cerebrovascular accidents			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 3 , 19 53 , to April 13 , 19 59 , that I last saw the deceased alive on April 13 , 19 59 , and that death occurred at 7:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Deer's Head State Hospital 4/14/59			
ACTUAL SIGNATURE V. Jaerman		M.D. Deer's Head State Hospital	
PHYSICIAN'S NAME (Type) V. Jaerman, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Removal	4-16-59	Deer's Head State Hospital	Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE Boaker & Co		ADDRESS Deer's Head State Hospital	
24a. REC'D BY REGISTRAR APR 21 1959		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

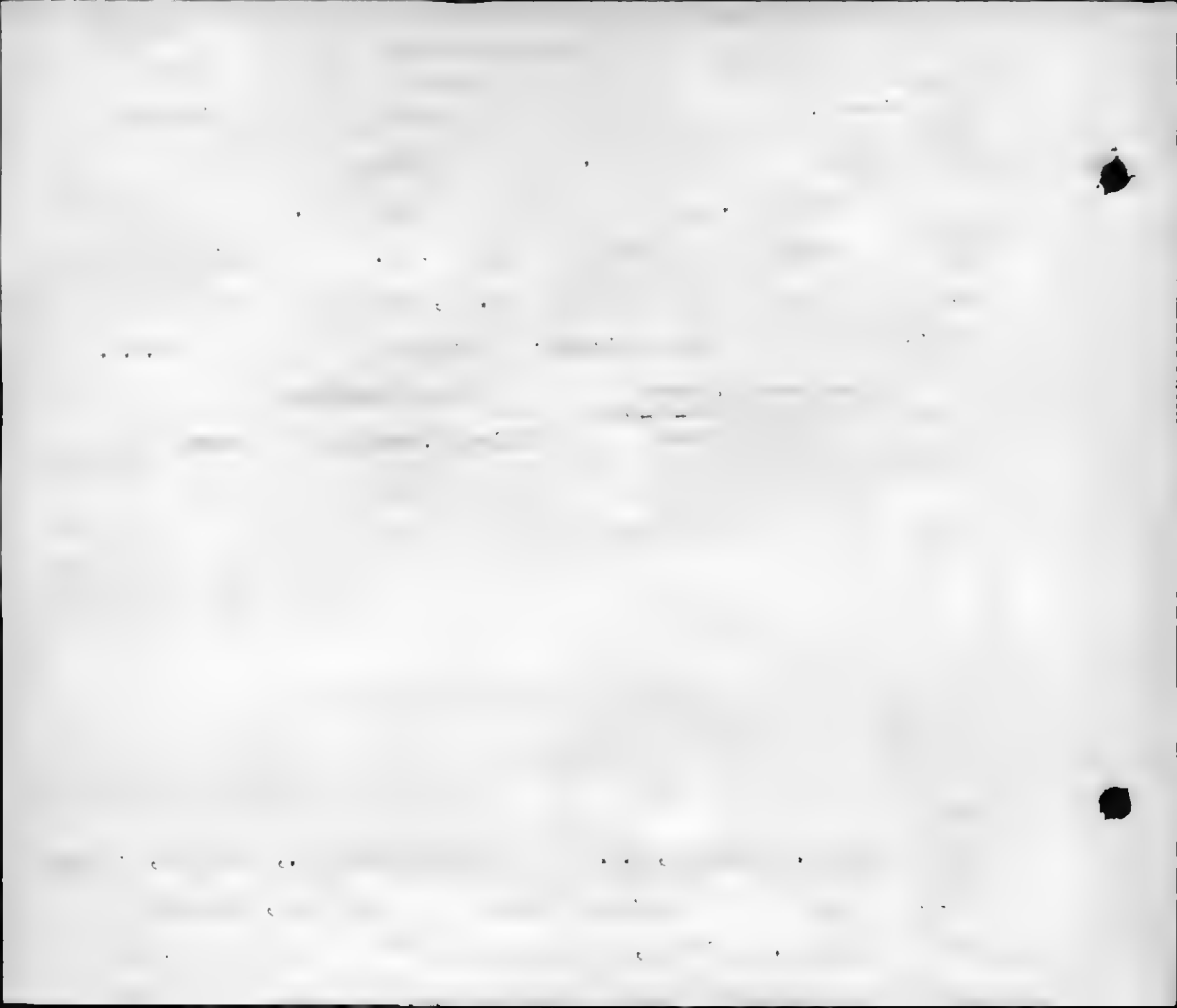
04922

4931

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 7 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Ave.				d. STREET ADDRESS Eastern Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle EDWARD Last JOHNSON, SR.				4. DATE OF DEATH Month April Day 8 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 20, 1874	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR: Months Days Hours Min		IF UNDER 24 HRS: Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Funeral Director		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Leonard Johnson				14. MOTHER'S MAIDEN NAME Emily Richardson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) NO (If yes, give war or dates of service) *****				16. SOCIAL SECURITY NO. 214-12-6632		17. INFORMANT William B. Johnson Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 yrs. (c) 1 hr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) degenerative heart disease							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3/16 , 19 59 , to 4/8 , 19 59 , that I last saw the deceased alive on 4/8 , 19 59 , and that death occurred at 10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md DATE SIGNED 4/10/59 ACTUAL SIGNATURE Earl M. B. Cardsley M.D. Earl M. B. Cardsley PHYSICIAN'S NAME (Type) Earl M. B. Cardsley, M.D. 207 Maryland Ave., Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/11/1959		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				40a. REC'D BY REGISTRAR DATE APR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

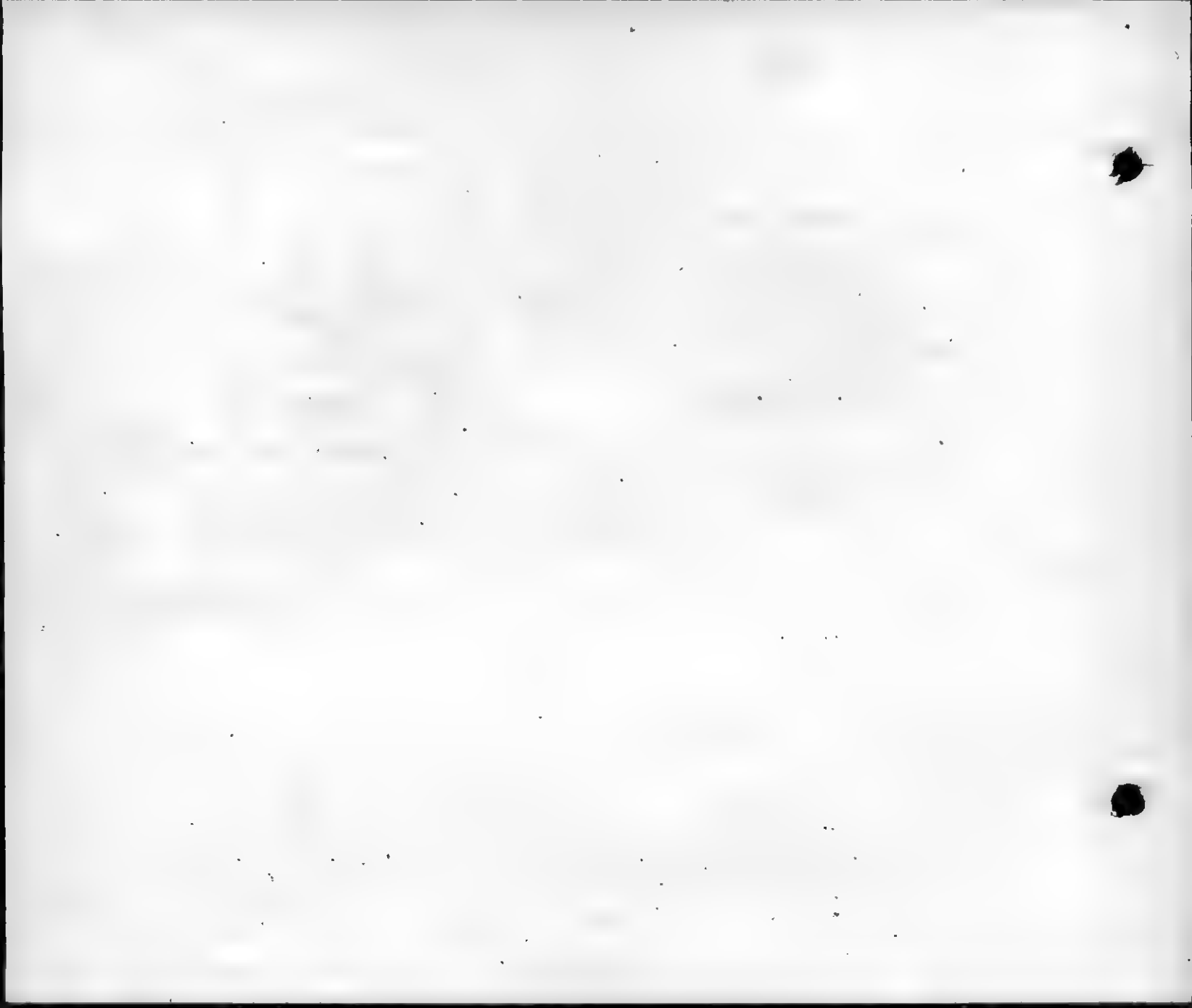


CERTIFICATE OF DEATH

Reg. Dist. No.

4932

1 PLACE OF DEATH o COUNTY <i>Wicomico</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) o STATE <i>MD</i> b COUNTY <i>Wicomico</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c LENGTH OF STAY IN 1b <i>2 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>Harrie</i> Middle <i>H.</i> Last <i>Jones</i>		4 DATE OF DEATH Month <i>April</i> Day <i>16</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>April 3 - 1897</i>
9 AGE (In years last birthday) <i>62</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Levin Bishop</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Sumell</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)	
16 SOCIAL SECURITY NO <i>none</i>		INFORMANT <i>Mr Willea Jones</i> Address <i>Snow Hill MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> DUE TO <i>Uremia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive C.V. Ruptured Aorta</i> (c) <i>2 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Uremia carcinoma Left Breast</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan</i> 1959 to <i>April 16</i> 1959, that I last saw the deceased alive on <i>April 16</i> 1959, and that death occurred at <i>5:30</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G. Herbert Sembley</i> M.D.		ADDRESS (Street, city or town, state) <i>400 E. Church St Salisbury MD</i> DATE SIGNED <i>7/18/59</i>	
PHYSICIAN'S NAME (Type) <i>G. Herbert Sembley</i>		<i>Salisbury MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>April 19/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Clings Cemetery</i>		22d. LOCATION (City, town, county) (State) <i>Snow Hill MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clayton E. Symms</i>		ADDRESS <i>Snow Hill MD</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE		APR 21 59	



1

4933

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

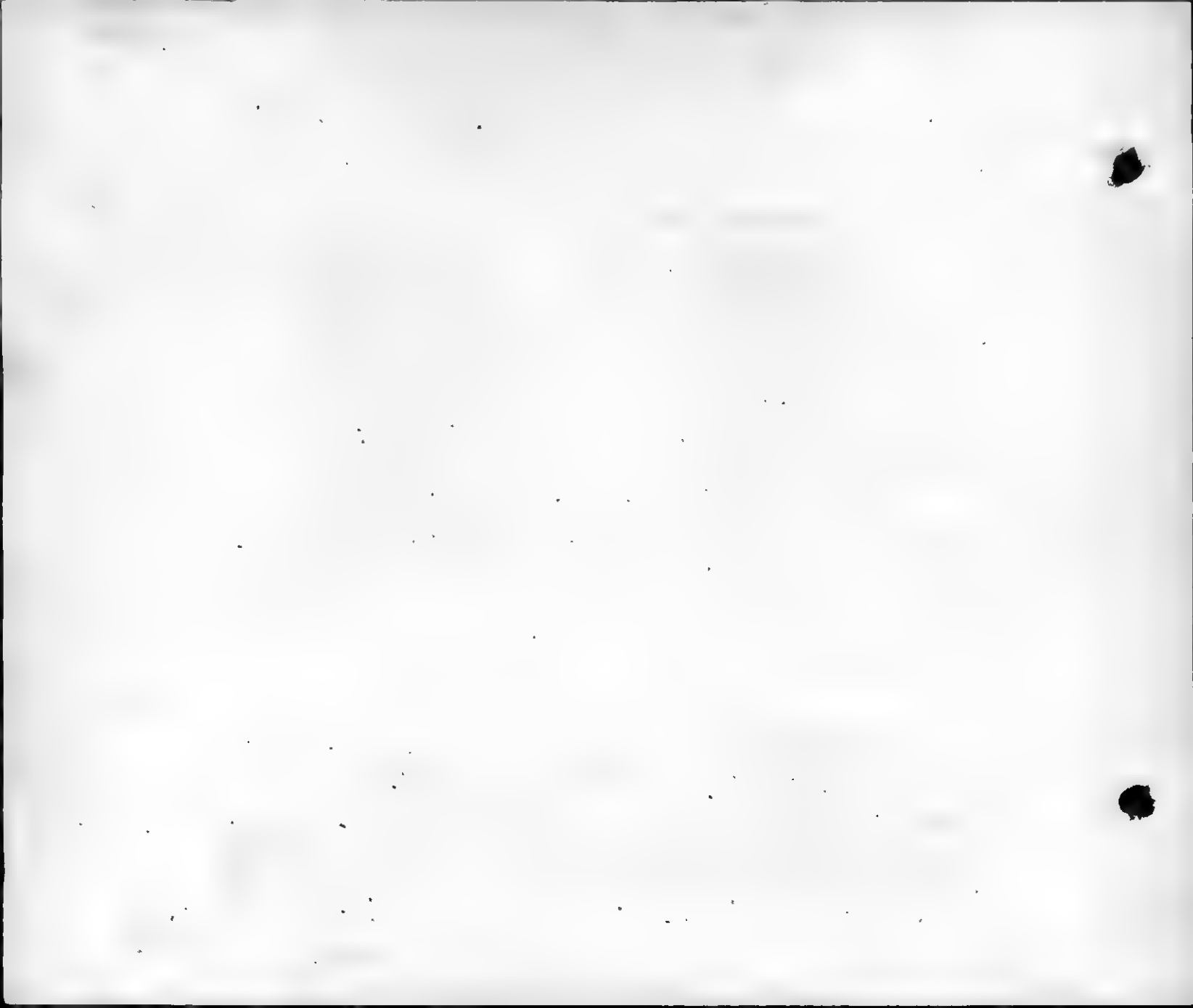
Items 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

CERTIFICATE OF DEATH

04924

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <u>md</u> c. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Viola</u> First <u>King</u> Middle <u>KING</u> Last		4. DATE OF DEATH Month <u>APRIL</u> Day <u>25</u> Year <u>1959</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>COLORED</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1906</u>
9 AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11 BIRTHPLACE (State or foreign country) <u>Princess Anne, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>John Curtis</u>		14 MOTHER'S MAIDEN NAME <u>Marysue Bell Curtis</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>none</u>		16 SOCIAL SECURITY NO <u>none</u>	
17 INFORMANT <u>Lindley King</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Chronic Artery Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Artery Insufficiency</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 19, 1959</u> to <u>April 25, 1959</u> that I last saw the deceased alive on <u>April 25, 1959</u> and that death occurred at <u>9:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>And J. G. G. G. G.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4/27/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. J. G. G. G.</u>		M.D. <u>Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-30-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Allen Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Allen md</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Robert M. Wash</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>MAY 5 '59</u>		<u>Arthur S. Kiser</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4934

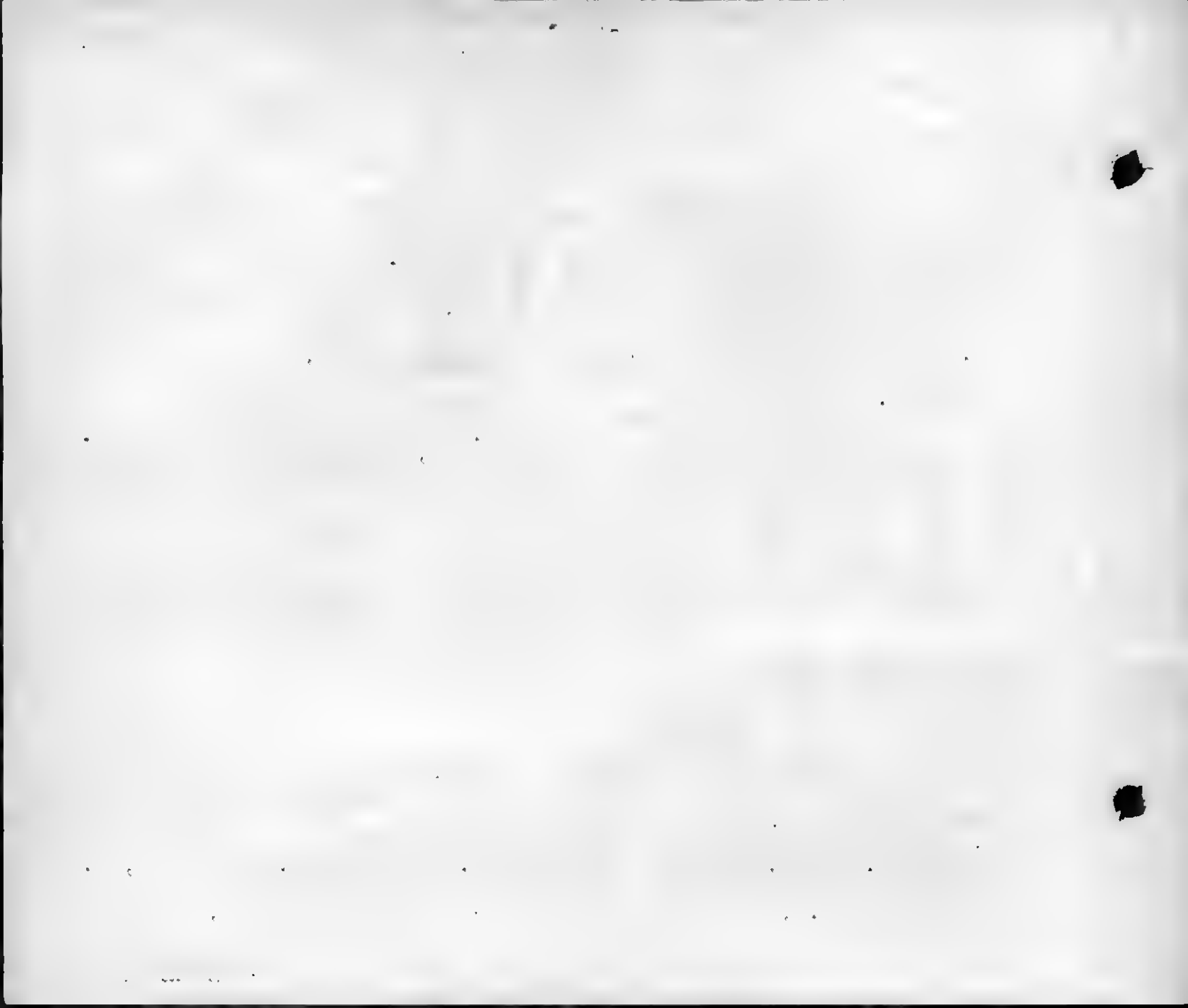
CERTIFICATE OF DEATH

04925

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a. STATE Maryland b COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 604 South Park Drive		f. STREET ADDRESS 604 South Park Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUIS Middle HENRY Last KRAUS SR.		4. DATE OF DEATH Month APRIL Day 5th Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1901
9. AGE (In years last birthday) 57 yrs		10. IF UNDER 1 YEAR Months 9 Days 28	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dr. of Pharmacy		10b. KIND OF BUSINESS OR INDUSTRY Pharmacist	
11. BIRTHPLACE (State or foreign country) Baltimore City, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Herman M. Kraus		14. MOTHER'S MAIDEN NAME Louise Elizabeth Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 17. INFORMANT Louis H. Kraus (Son) 431 Virginia Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 470.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Sudden
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/5 , 19 59 to 12:30A , 19 59 , that I last saw the deceased alive on 4/5 , 19 59 , and that death occurred at 12:30A , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED April 6 /1959			
ACTUAL SIGNATURE Fred R. Gramse M.D.		PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse 402 S. Division St. Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Apr. 8, 1959	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR APR 9 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

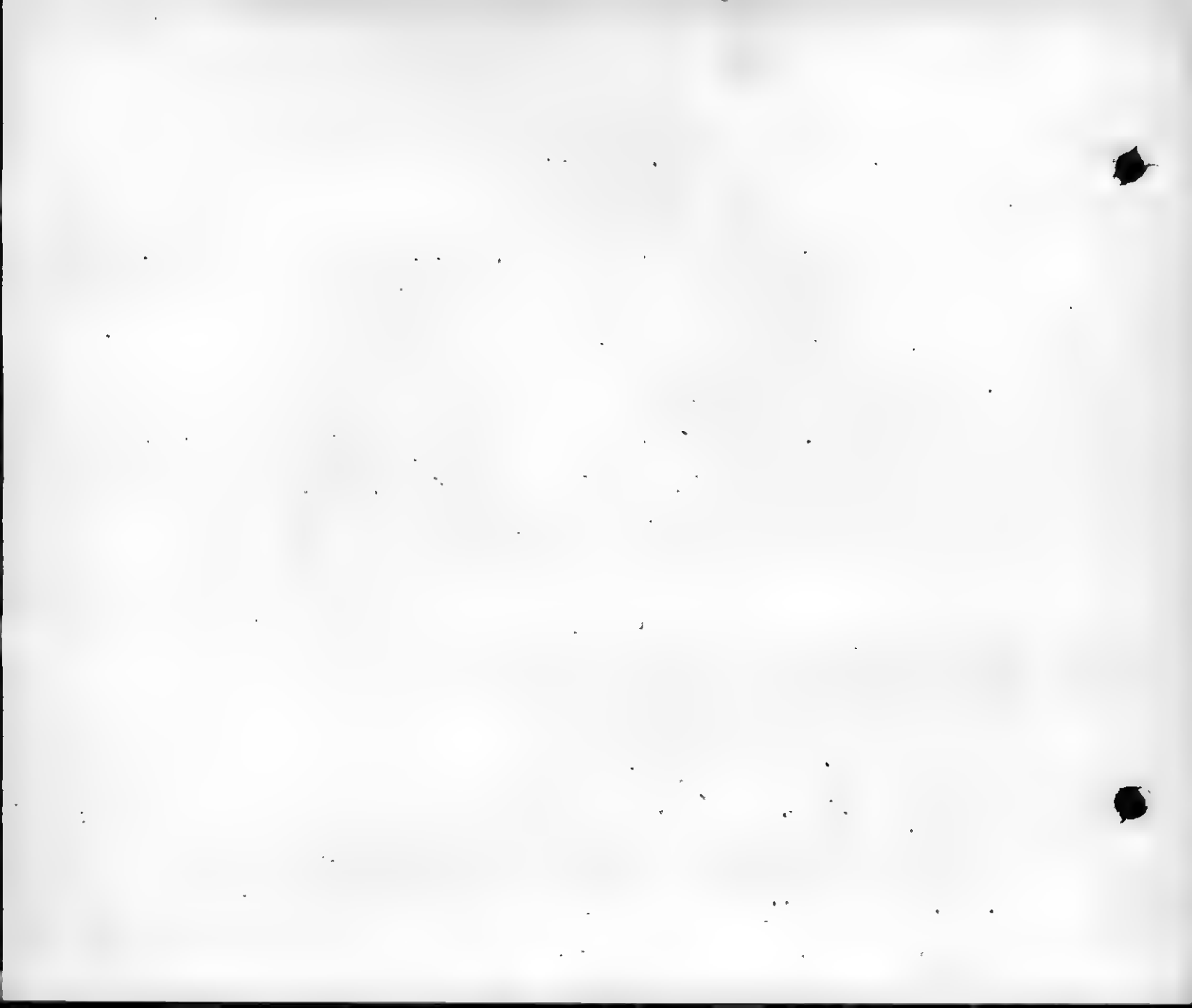
Reg. Dist. No.

4935

1. PLACE OF DEATH a. COUNTY <u>Delaware</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seaford</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seaford</u> 46X-11			
c. LENGTH OF STAY IN TB <u>4 HR 20 min</u>				d. STREET ADDRESS <u>Nanticoke Annex</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY GIRL Lynch</u>				4. DATE OF DEATH Month Day Year <u>April 23 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 22, 1959</u>	
9. AGE (In years lost birthday) yrs. <u>4</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>20</u>		IF UNDER 24 HRS Hours <u>4</u> Min <u>20</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>INFANT</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>RICHARD T. Lynch</u>				14. MOTHER'S MAIDEN NAME <u>ELVA L. JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
INFORMANT Address <u>RICHARD T. Lynch - SEAFORD, DEL.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Placental, fetal type</u> <u>762.0</u> DUE TO <u>Cerebral edema and Congestion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Spontaneous (Birth at 1654 gms)</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 22, 1959</u> to <u>April 23, 1959</u> that I last saw the deceased alive on <u>April 23, 1959</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. W. SAUNDERSON JR</u> M.D.				DATE SIGNED <u>April 23, 1959</u>			
PHYSICIAN'S NAME (Type) <u>RW. SAUNDERSON JR</u>				<u>Seaford, Del</u>			
22a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BLADES Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>BLADES, DELAWARE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Medford L. Watson Jr</u>				ADDRESS <u>SEAFORD, DEL.</u>			
24a. REC'D BY REGISTRAR <u>APR 29 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hearn</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

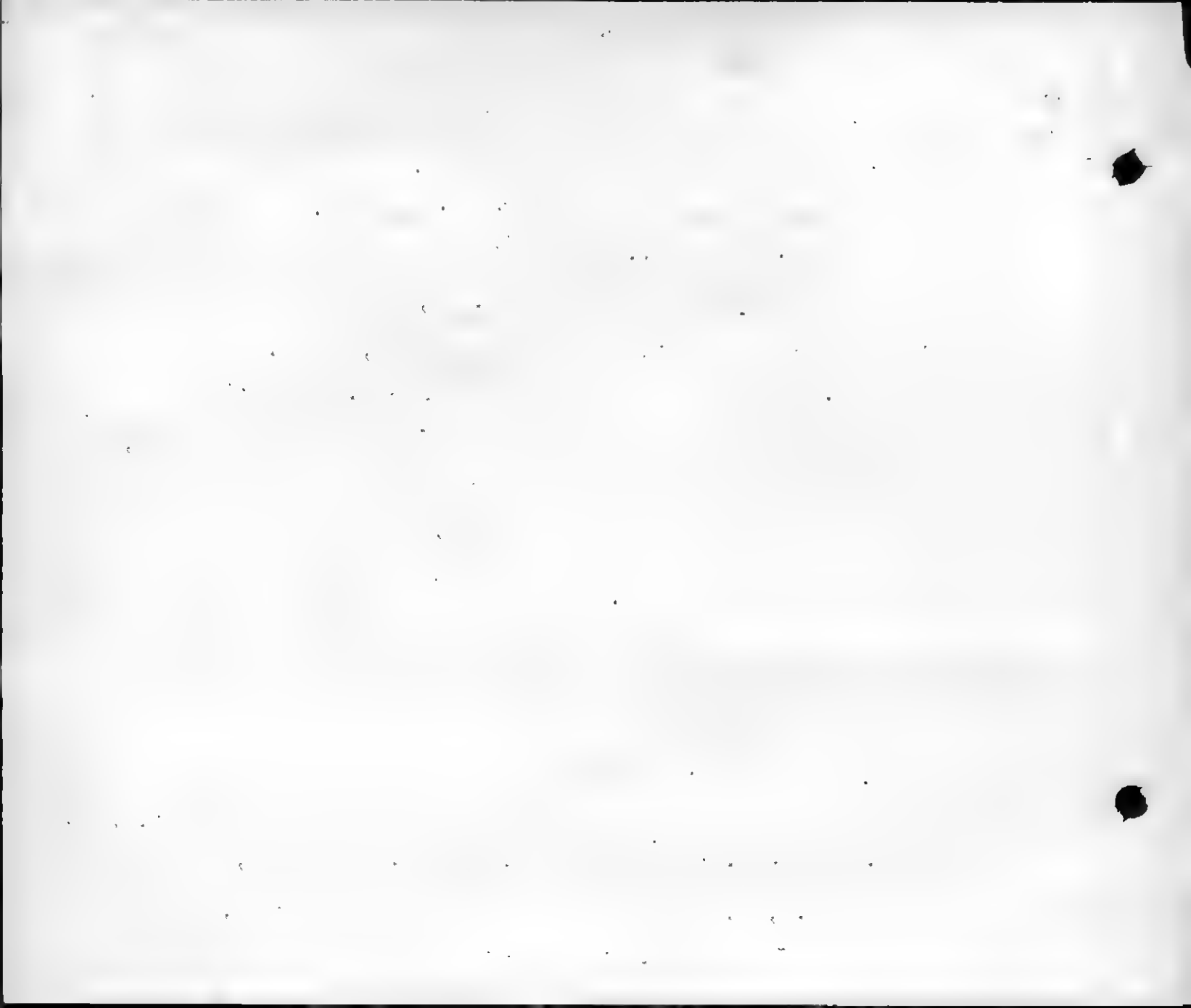
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4936

CERTIFICATE OF DEATH

04927
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury 12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>703 Riverside Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BENJAMIN T. MADDOX</u>		4. DATE OF DEATH Month Day Year <u>April 5 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer- Lumber Mill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mill Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William B. Maddox</u>		14. MOTHER'S MAIDEN NAME <u>Virginia B. McCallister</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Mr. Harry L. Hitchens (Brother-in-Law)</u>		18. ADDRESS <u>703 Riverside Road Salisbury, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary Artery Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 hrs</u> <u>2-3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> to <u>April 5, 1959</u> , that I last saw the deceased alive on <u>April 5, 1959</u> , and that death occurred at <u>10:35</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Gray</u> M.D.		DATE SIGNED <u>Apr. 6/1959</u>	
PHYSICIAN'S NAME (Type) <u>Dr. William D. Gray</u>		<u>Camden Ave. Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 9, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04928

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>10 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>521 Race St.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>521 Race St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Frances</u> First <u>Marshall</u> Middle Last		4. DATE OF DEATH <u>4-7-</u> Month <u>19</u> Day <u>59</u> Year		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec 1-1908</u>		9. AGE (In years last birthday) <u>50</u> <u>4/6</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Newark, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John T. Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Martha Chesser</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Dr. Oswald Hardy, Lane De Guac, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>716.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Third degree burns 100 % body surface.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Smoking in bed and bed and house burned.</u>															
20c. TIME OF INJURY Month, Day, Year <u>1</u> Hour <u>A.M.</u> <u>4-7-59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Own Home.</u>				20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Md.</u>							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>4-9-59</u>											
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22a. NAME OF CEMETERY OR CREMATORY <u>Brown Methodist Cemetery</u>				22b. LOCATION (City, town, or county) <u>Newark, Md</u>							
22c. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22d. DATE THEREOF <u>April 9/59</u>				22e. NAME OF CEMETERY OR CREMATORY <u>Snout Hill, Md</u>				22f. LOCATION (City, town, or county) <u>Newark, Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton J. Smith</u>				24. REC'D BY REGISTRAR <u>APR 13 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>											



4938

CERTIFICATE OF DEATH

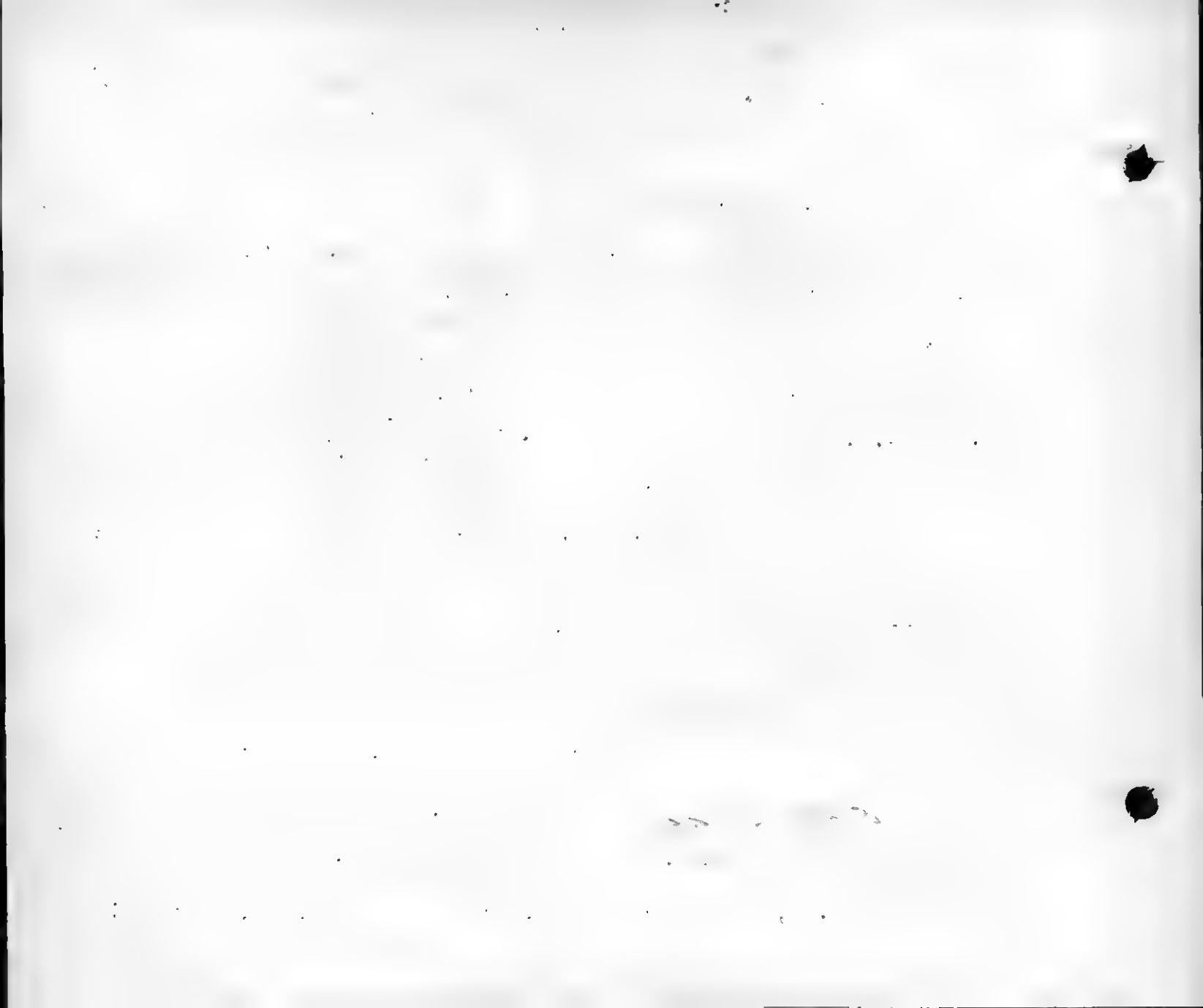
04929

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admision) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle Race Last Marvel		4. DATE OF DEATH Month April Day 23 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/1894
9. AGE (In years last birthday) yrs. 64		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Franklin Marvel		14. MOTHER'S MAIDEN NAME Clara Belle Beach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.# 1		16. SOCIAL SECURITY NO. INFORMANT Hospital Records	
17. ADDRESS Mrs. Mary Marvel (wife) Railroad St Hebron, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Esophageal varicose veins - bleeding 4/23/59 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Myocardial insufficiency DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis, multiple; diabetes			INTERVAL BETWEEN ONSET AND DEATH ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 6, 1959 to April 23, 1959 , that I last saw the deceased alive on April 23, 1959 , and that death occurred at 11:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Kosmahly M.D.		ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 4/23/59	
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 25, 1959	
22c. NAME OF CEMETERY OR CREMATORY Fireman's Cemetery		22d. LOCATION (City, town, or county) (State) Sharptown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE APR 27 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hunt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

04930
Reg. Dist. No

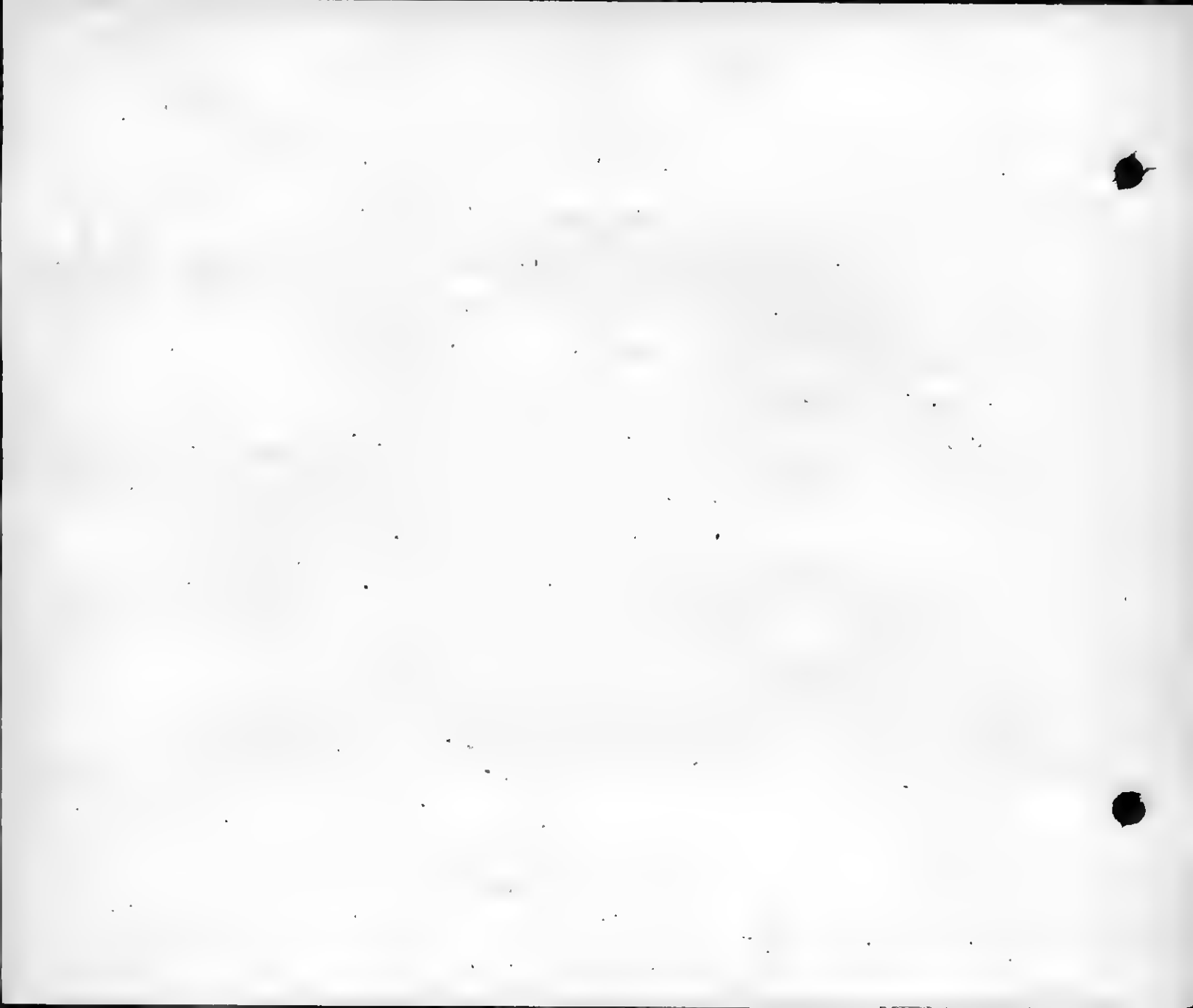
4939

1 PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>26 HOURS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>11TH STREET</u>	
3. NAME OF DECEASED (Type or print) <u>Ruth P. Mathias</u>		4. DATE OF DEATH <u>April 9 - 1959</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>TWIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></u>	8 DATE OF BIRTH <u>JAN. 16, 1913</u>
9 AGE (In years last birthday) <u>46</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE + BANK TELLER</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>BANKING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN L. POLLARD</u>	
14. MOTHER'S MAIDEN NAME <u>EVA KELLEY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16 SOCIAL SECURITY NO. <u>214-36-5233</u>		INFORMANT <u>RALPH S. MATHIAS, Pocomoke City, MD.</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO <u>Adenocarcinoma Endometrium</u> with <u>Generalized Metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma Endometrium</u> (c) <u>with Generalized Metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 9, 1955</u> to <u>Apr 9, 1959</u> that I last saw the deceased alive on <u>Apr 7, 1959</u> and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>River St. Watson, M.D.</u>		ADDRESS (Street, city or town, state) <u>Salisbury, MD.</u> DATE SIGNED <u>4-2-59</u>	
PHYSICIAN'S NAME (Type) <u>River St. Watson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-12-59</u>	22c. NAME OF CEMETERY OR <u>MT. HOLLY</u>	22d. LOCATION (City, town, or county) (State) <u>ONANCOCK, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		24a. REC'D BY REGISTRAR <u>APR 14 '59</u>	
ADDRESS <u>Pocomoke City, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

1
b
11
082

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal of the body.

VS A15 (4)
ISM 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

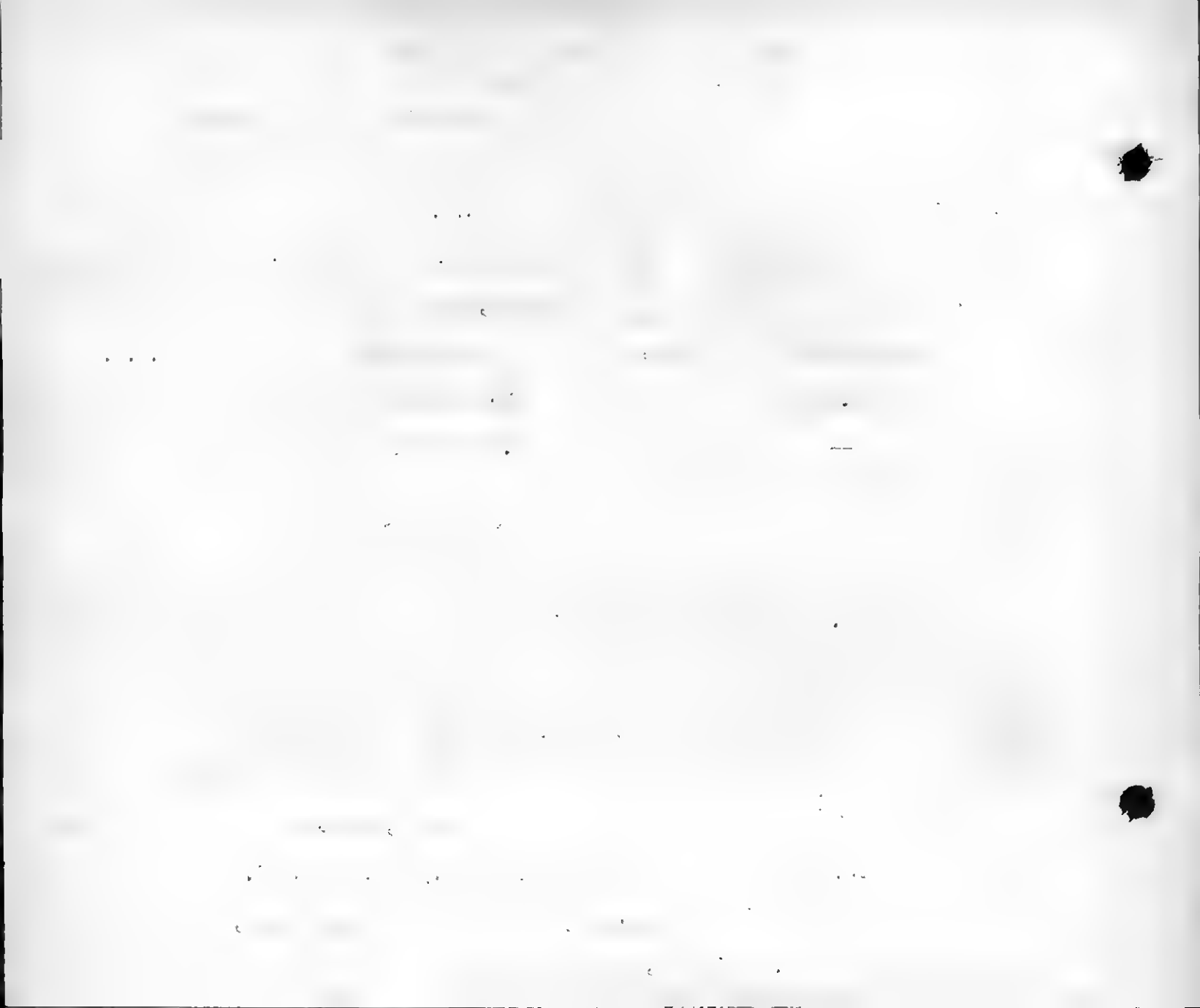
4940

CERTIFICATE OF DEATH

Reg. Dist. No. 04931

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b 2 WKS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE EDNA MAXWELL		4. DATE OF DEATH Month Day Year APRIL 15 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1900
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Maxwell		14. MOTHER'S MAIDEN NAME Mary Bernard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Ethel Adkins, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC PYELONEPHRITIS DUE TO (c) TUBERCULOSIS OF KIDNEY		INTERVAL BETWEEN ONSET AND DEATH 2 weeks Year Year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MALIGNANT HYPERTENSION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1958 to 4/15/1959 , that I last saw the deceased alive on 4/15/1959 , and that death occurred at 9:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		DATE SIGNED 4/15/59	
PHYSICIAN'S NAME (Type) O. J. Burton		ADDRESS 211 Maryland Ave., Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/59	
22c. NAME OF CEMETERY OR CREMATORY Stonington, Cemetery		22d. LOCATION (City, town, or county) (State) Stonington, Conn	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		24a. REC'D BY REGISTRAR DATE APR 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoms			

Norman T. Rakey



4967

CERTIFICATE OF DEATH

04932

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 39 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 401 S. Division St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARSHALL Middle LEMUEL Last MITCHELL		4. DATE OF DEATH Month April Day 27 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1883
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pres. of Pepsi-Cola Bottling Co.		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel Mitchell	
14. MOTHER'S MAIDEN NAME Emma Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Ida W. Mitchell, Same Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/10 , 19 57 , to 4/27 , 19 59 , that I last saw the deceased alive on 4/27 , 19 59 , and that death occurred at 11:22 P. M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 4/30/59	
ACTUAL SIGNATURE Fred R. Gramse M.D.		PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse 402 South Division St., Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/30/59	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland ADDRESS		24a. REC'D BY REGISTRAR MAY 4 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

1
4
M
I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4967

CERTIFICATE OF DEATH

04932

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY **Wicomico** MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Maryland** b. COUNTY **Wicomico**

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Salisbury**

c. LENGTH OF STAY IN 1b **39 Yrs.**

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION **401 S. Division St.,**

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First **MARSHALL** Middle **LEMUEL** Last **MITCHELL**

4. DATE OF DEATH
Month **April** Day **27** Year **19 59**

5. SEX **Male**

6. COLOR OR RACE **White**

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH **March 20, 1883**

9. AGE (In years last birthday) **76** yrs

10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Pres. of Pepsi-Cola Bottling Co.**

11. BIRTHPLACE (State or foreign country) **Delaware**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Daniel Mitchell**

14. MOTHER'S MAIDEN NAME **Emma Smith**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **No** (If yes, give year or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT **Mrs. Ida W. Mitchell, Same** Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Coronary Occlusion**
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **Sudden**
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. **19**

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **12/10**, 19**57**, to **4/27**, 19**59**, that I last saw the deceased alive on **4/27**, 19**59**, and that death occurred at **11:22** P. M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **Salisbury, Maryland** DATE SIGNED **4/30/59**

ACTUAL SIGNATURE **Fred R. Gramse** M.D.

PHYSICIAN'S NAME (Type) **Dr. Fred R. Gramse 402 South Division St., Salisbury, Maryland**

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

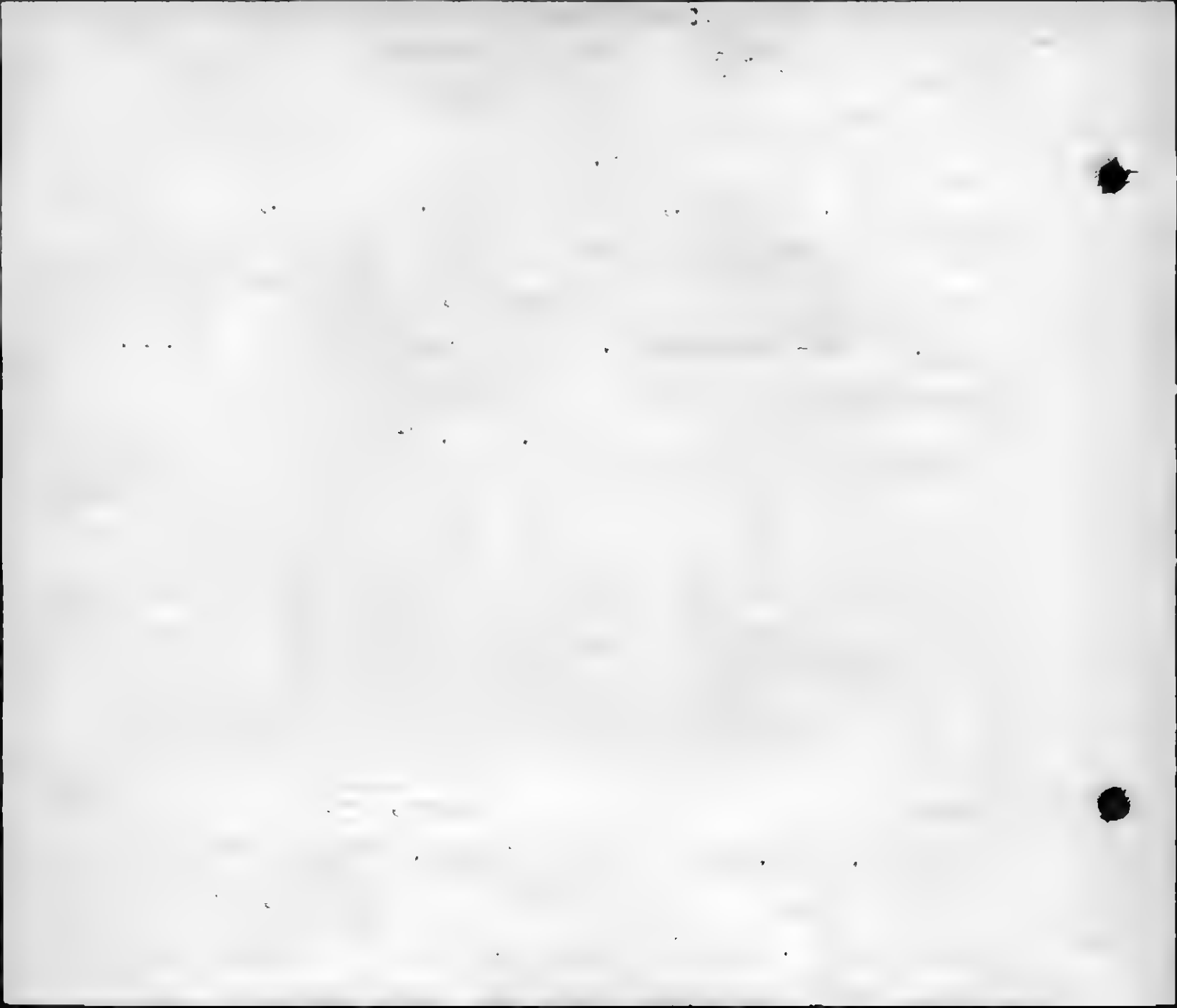
22b. DATE THEREOF **4/30/59**

22c. NAME OF CEMETERY OR CREMATORY **Parsons Cemetery**

22d. LOCATION (City, town, or county) (State) **Salisbury, Maryland**

23. FUNERAL DIRECTOR'S SIGNATURE **Hill & Johnson Co. Salisbury, Maryland** ADDRESS

24a. REC'D BY REGISTRAR **MAY 4 '59** 24b. REGISTRAR'S SIGNATURE **Arthur L. Kline**



4941
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o STATE Maryland b COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 1309 Ashland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Vander Middle Morris Last Morris				4. DATE OF DEATH Month April Day 6 Year 19 59			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/12/08		9. AGE (In years last birthday) yrs 51	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hyman Roe				14. MOTHER'S MAIDEN NAME Morris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial asthma DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 yrs 10 yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 026X Neurosyphilis with optic atrophy, treated.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Mar. 24 , 19 59 , to April 6 , 19 59 , that I last saw the deceased alive on April 6 , 19 59 , and that death occurred at 7:15A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Juerman				ADDRESS (Street, city or town, state) Deer's Head State Hospital		DATE SIGNED 4/6/59	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-10-59		22c. NAME OF CEMETERY OR CREMATORY Rockaway Cemetery		22d. LOCATION (City, town, or county) (State) Rockaway Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. ...				ADDRESS ...		24a. REC'D BY REGISTRAR DATE APR 16 '59	
						24b. REGISTRAR'S SIGNATURE Arthur L. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

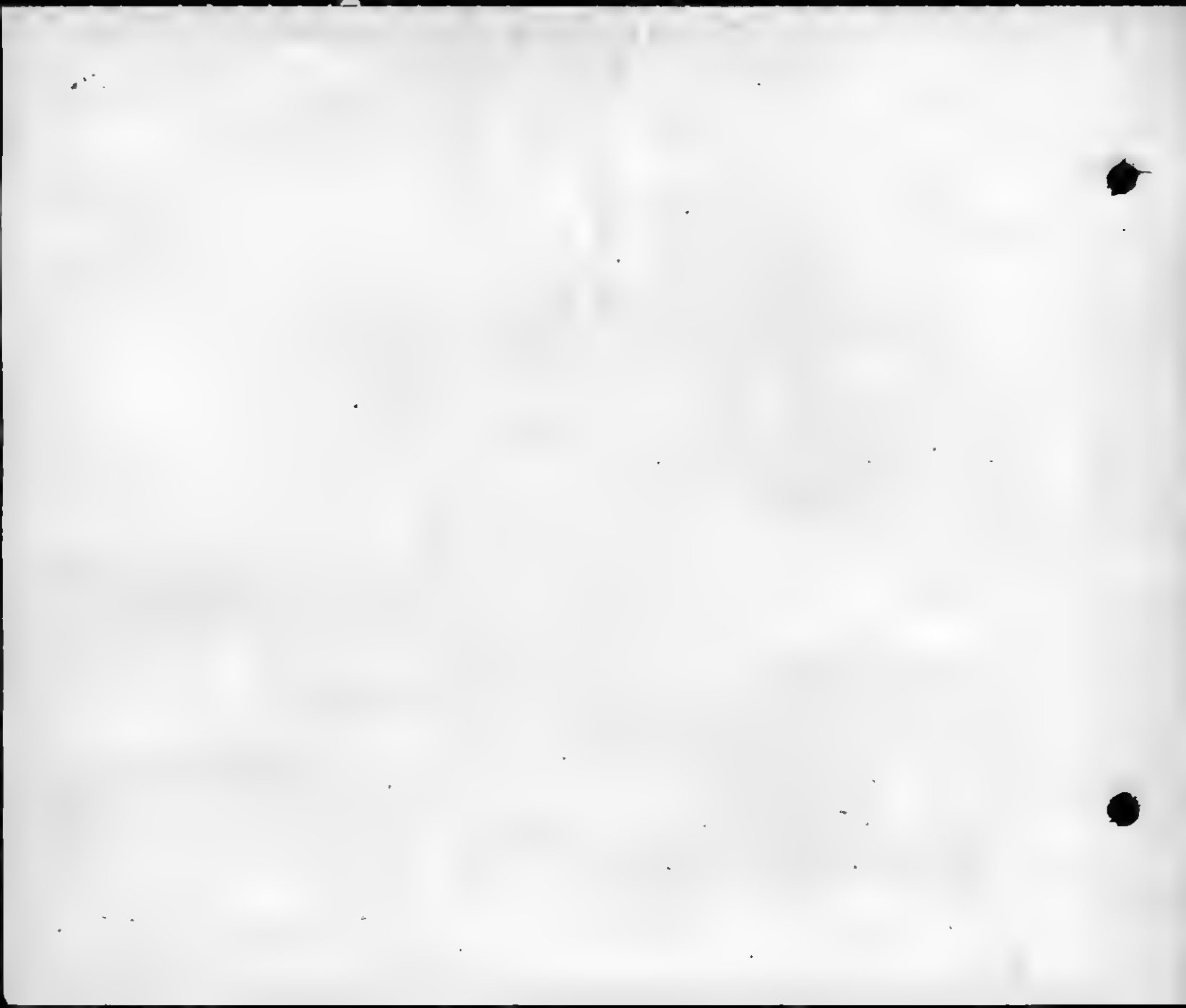
4942

CERTIFICATE OF DEATH

04934

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2,401 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Fairmount		19x		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Moody		First Moody		Middle L.		Last Muir		4. DATE OF DEATH Month April		Day 16		Year 1959		5. SEX Male		6. COLOR OR RACE White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/17/1877		9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Lambert Muir		14. MOTHER'S MAIDEN NAME Mary Virginia Evans		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk.			
16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute heart failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, general DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs Years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of rectum		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o m p. m 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Salisbury		(County) Maryland		(State) Maryland		21. I certify that I attended the deceased from Sept. 18, 1952 , to April 16, 1959 , that I last saw the deceased alive on April 16, 1959 , and that death occurred at 5:20 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Deer's Head State Hospital		DATE SIGNED 4/17/59		ACTUAL SIGNATURE G. Kosmahly		M.D.			
PHYSICIAN'S NAME (Type) G. Kosmahly, M.D.		Salisbury, Maryland		22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 4-18-59		22c. NAME OF CEMETERY OR CREMATORY Muir Cemetery		22d. LOCATION (City, town, or county) Fairmount		(State) Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Hume		ADDRESS Arthur S. Hume			
24a. REC'D BY REGISTRAR DATE APR 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume		24c. REGISTRAR'S SIGNATURE Arthur S. Hume		24d. REGISTRAR'S SIGNATURE Arthur S. Hume		24e. REGISTRAR'S SIGNATURE Arthur S. Hume		24f. REGISTRAR'S SIGNATURE Arthur S. Hume		24g. REGISTRAR'S SIGNATURE Arthur S. Hume		24h. REGISTRAR'S SIGNATURE Arthur S. Hume		24i. REGISTRAR'S SIGNATURE Arthur S. Hume			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

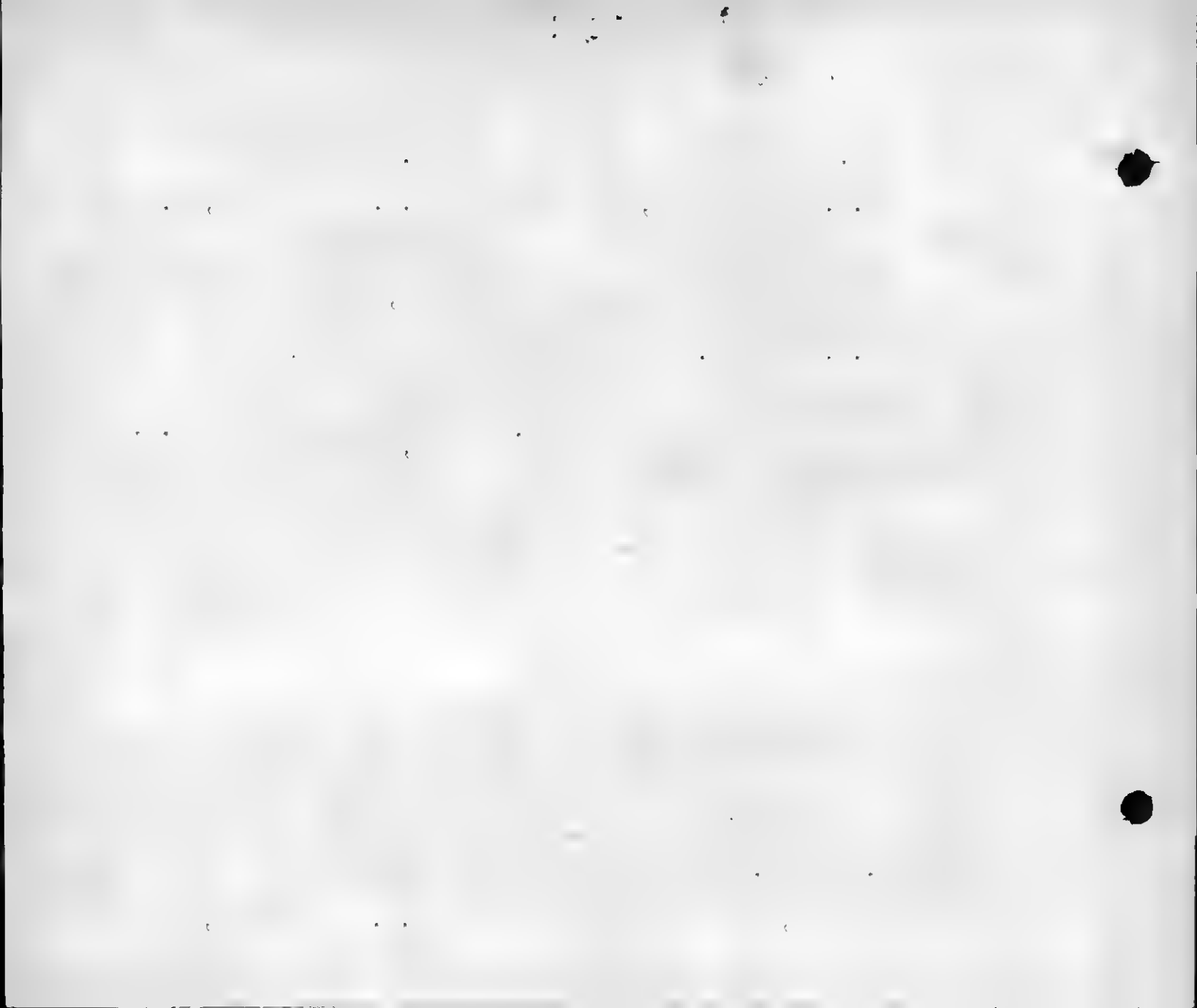
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04935

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Hermon		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Hermon	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# Salisbury, Md		d. STREET ADDRESS R.D.# Salisbury, Md.	
3. NAME OF DECEASED (Type or print) First HENRY Middle SAMSON Last PARKER		4. DATE OF DEATH Month APRIL Day 28th Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 20, 1893
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 6 Days 8 Hours Min. 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee-H.D. Metal Co. (Night Watchman) Powellville, Md		10b. KIND OF BUSINESS OR INDUSTRY U S A	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Henry Parker		14. MOTHER'S MAIDEN NAME Lucy Adkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Lula Williams (Daughter) R.D.#3 Laurel, Delaware		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dr. Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		DATE April 29 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 1, 1959	22c. NAME OF CEMETERY OR CREMATORY Charity Cemetery R.D.# Salisbury, Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR SALISBURY MARYLAND	
24b. REGISTRAR'S SIGNATURE DATE MAY 1 '59		24c. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

04936

Reg. Dist. No.

1943

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury, Md.		LENGTH OF STAY (in this place) Since 4/11/58		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Parsonsborg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine Bluff State Hospital Salisbury, Maryland				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) Minnie Lillian Parker				4. DATE OF DEATH (Month) (Day) (Year) April 10 1959			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct. 28, 1880		9. AGE last birthday 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Parsonsborg, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Campbell				14. MOTHER'S MAIDEN NAME Sophia Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Records of Pine Bluff State Hospital Mr. J. Albert Parker-Parsonsborg, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Pulmonary Tuberculosis						3 yrs.	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic cardiovascular disease						5 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 11, 1958 , to April 10, 1959 , that I last saw the deceased alive on April 10, 1959 , and that death occurred at 10:53p.M. from the causes and on the date stated above.							
SIGNATURE Edward P. Ritchie M.D.				ADDRESS (Street, city, town, state) Salisbury, Md.		DATE SIGNED 4/11/59 (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Apr. 14, 1959		NAME OF CEMETERY OR CREMATORY Parsonsborg, Cemetery		LOCATION (City, town, or county) Parsonsborg, Md.	
24. REC'D BY REGISTRAR APR 15 '59 DATE		REGISTRAR'S SIGNATURE Arthur S. House		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY -SALISBURY MD.			

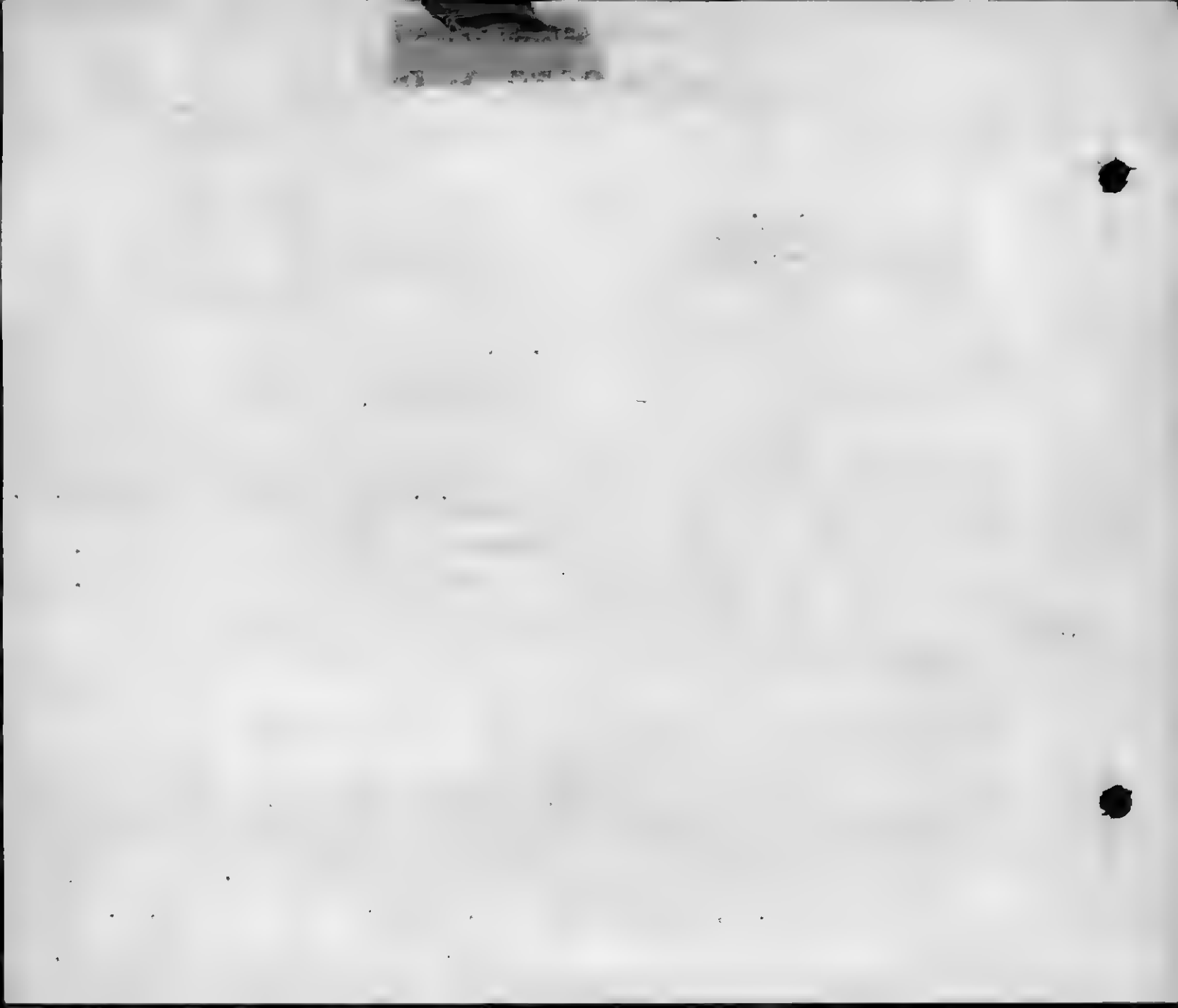
INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

19 Item 18 Film 242 5-11-59 ams										20 Item 7 Film 6-11-59 ams									
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND										2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lattisburg</u>										c. LENGTH OF STAY IN 1b <u>12</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wicomico General</u>										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Lee</u> Last <u>Porter</u>										4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1959</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 14, 1895</u>		9. AGE (In years last birthday) <u>63</u> yrs		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u> Hours <u>15</u> Min <u>0</u>		11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, event if retired) <u>Housewife</u>										10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>									
11. BIRTHPLACE (State or foreign country) <u>Blaine</u>										12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>James Morris</u>										14. MOTHER'S MAIDEN NAME <u>Janie Post</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>										16. SOCIAL SECURITY NO. <u>None</u>									
17. INFORMANT <u>John Porter</u> Address <u>Lattisburg Md</u>																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential hypertension</u> DUE TO (c) <u>2 yrs.</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>4/28</u> , 19 <u>59</u> , to <u>4/29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/28</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.																			
ACTUAL SIGNATURE <u>Earl A. Boardley</u> M.D. <u>Lattisburg, Md</u>										DATE SIGNED <u>4/29/59</u>									
PHYSICIAN'S NAME (Type) <u>Earl A. Boardley</u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										22b. DATE THEREOF <u>5/1/59</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>Littlety</u>										22d. LOCATION (City, town, or county) (State) <u>Parkside Va</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Richard Johnson</u> ADDRESS <u>Parkside, Va</u>										24a. REC'D BY REGISTRAR <u>Arthur E. Kline</u> DATE <u>MAY 4 '59</u>									
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>																			



Reg. Dist. No.

04938

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 371 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 203 N. 2nd Street	
3. NAME OF DECEASED (Type or print) First Hattie Middle Louise Last Quillen		4. DATE OF DEATH Month April Day 1 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1893
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 0 Hours 0 Min. 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
12. BIRTHPLACE (State or foreign country) Ocean City, Maryland		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME Robert C. Quillen		15. MOTHER'S MAIDEN NAME Hattie Henman	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		17. SOCIAL SECURITY NO. NO	
18. INFORMANT Hospital Records, Salisbury, Maryland		19. ADDRESS Hospital Records, Salisbury, Maryland	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized carcinomatosis 110X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca of breast DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH ? 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple sclerosis		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
23a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		23b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
24a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24b. (City or town) (County) (State)	
25. I certify that I attended the deceased from March 25, 1958 , to April 1, 1959 , that I last saw the deceased alive on April 1, 1959 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED Deer's Head State Hospital 4/1/59			
ACTUAL SIGNATURE L.V. Maldve, M. D. M.D. Salisbury, Maryland			
26a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		26b. DATE THEREOF 1/4/59	
26c. NAME OF CEMETERY OR CREMATORY EVERGREEN		26d. LOCATION (City, town, or county) (State) BERLIN MD	
27. FUNERAL DIRECTOR'S SIGNATURE Anna R. Burbage		28. ADDRESS Berlin Md	
29a. REC'D BY REGISTRAR DATE APR 6 '59		29b. REGISTRAR'S SIGNATURE Arthur S. Thraus	

VS A15 (4)
15M 9/55



4946

CERTIFICATE OF DEATH

04939
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN TB <u>21</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA MARIE Ross</u>		4. DATE OF DEATH Month Day Year <u>APRIL 15 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1938</u>
9. AGE (In years last birthday) <u>21</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN HANCOCK</u>		14. MOTHER'S MAIDEN NAME <u>EDNA KIRK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>20113187</u>	
17. INFORMANT <u>WILLIAM B. RILEY</u>		Address <u>Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Mycobacterial Infection</u> 422- DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1.2.5.7</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1.2.5.7</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-15</u> , 19 <u>59</u> , to <u>4-15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-15</u> , 19 <u>59</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William B. Riley</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>4-15-59</u>	
PHYSICIAN'S NAME (Type) <u>William B. Riley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>13</u>	22b. DATE THEREOF <u>4-19-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Thomas</u>		ADDRESS <u>Salisbury, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

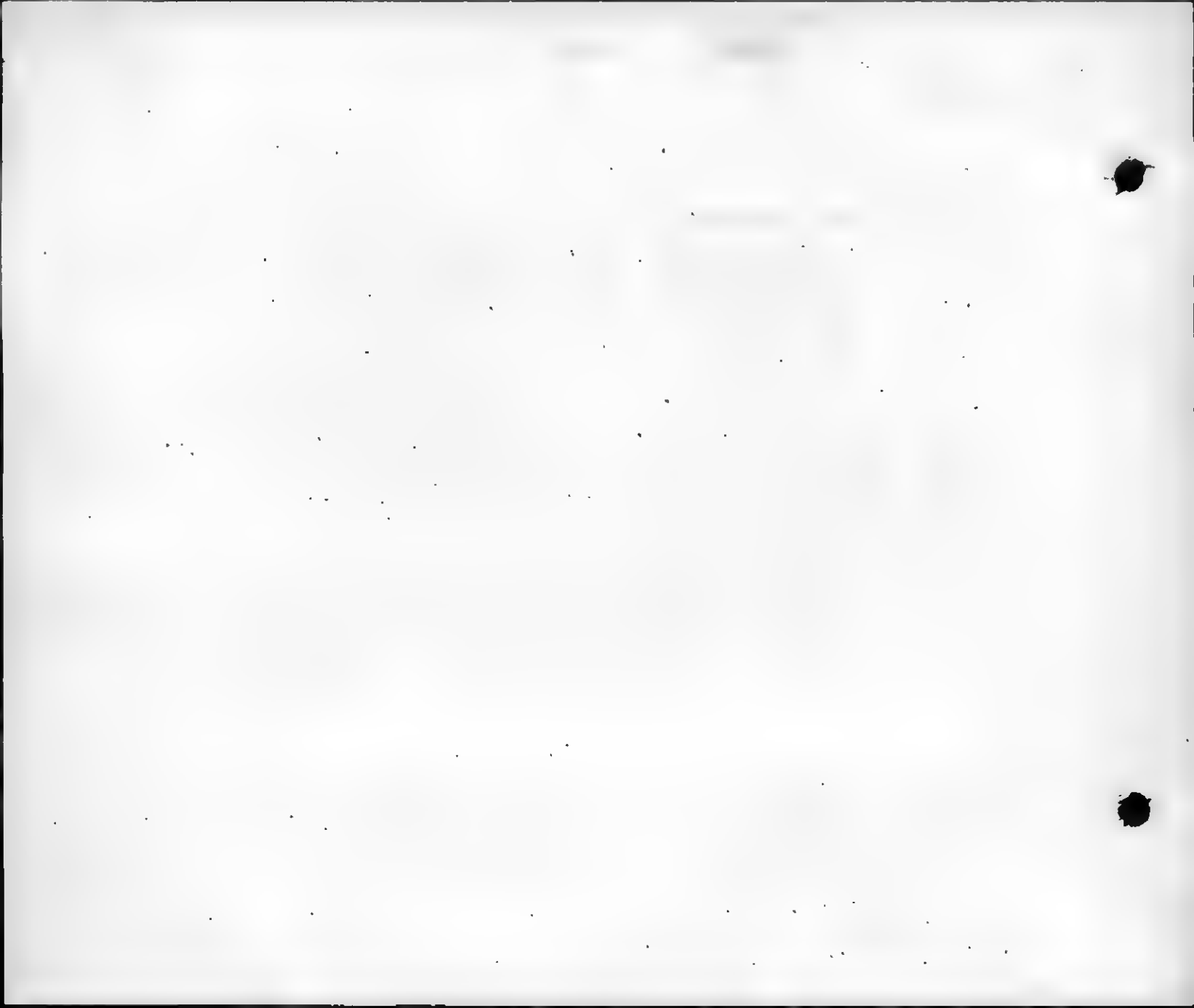
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper.

Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4969

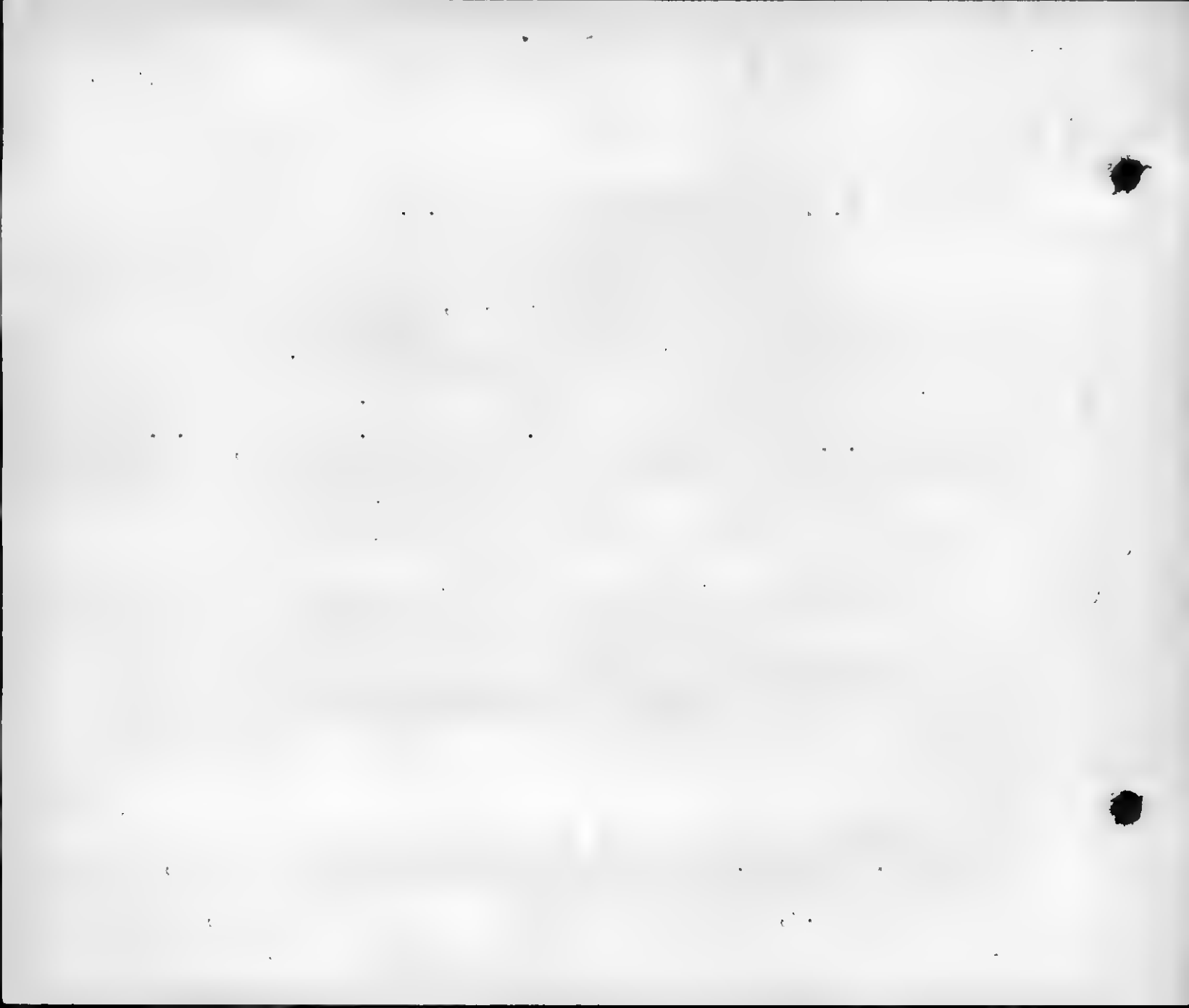
CERTIFICATE OF DEATH

04940

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b X Salisbury (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 3 (Walston)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle WALTER Last SMITH		4. DATE OF DEATH Month APRIL Day 4th Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1890
9. AGE (In years last birthday) 68 yrs		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee (Manager) Bond Bakers		10b. KIND OF BUSINESS OR INDUSTRY Wicomico Co. Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Washington Smith		14. MOTHER'S MAIDEN NAME Mary E. Hearne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES W.W. #1		16. SOCIAL SECURITY NO. W.W. #1	
17. INFORMANT Mrs. Henrietta G. Smith (Wife) R.D.# 3 (Walston) Salisbury, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Coronary Artery Disease with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Left Ventricular Enlargement and Aortic Stenosis (b) Left Ventricular Enlargement and Aortic Stenosis (c) Left Ventricular Enlargement and Aortic Stenosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 4, 1957 to April 4, 1959 , that I last saw the deceased alive on Feb 3, 1959 , and that death occurred at 2:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pine Bluff Road Salisbury, Maryland DATE SIGNED April 7, 1959			
ACTUAL SIGNATURE Thomas C. Hill Jr. M.D.			
PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill Jr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 7, 1959	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR APR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4970

CERTIFICATE OF DEATH

04941

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden Rural #2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Rural #2</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah Mae Stanford</u>		4. DATE OF DEATH <u>April 13 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20 - 1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13. FATHER'S NAME <u>Edward J. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Lynwood Hargis</u>		Address <u>Snow Hill, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension C.V. Disease</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/11/59</u> 19 <u>59</u> , to <u>4/13</u> 19 <u>59</u> , that I last saw the deceased alive on <u>4/11</u> 19 <u>59</u> , and that death occurred at <u>7</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William B. Smith</u>		DATE SIGNED <u>4/13/59</u>	
PHYSICIAN'S NAME (Type) <u>DR. WILLIAM B. SMITH</u>		ADDRESS (Street, city or town, state) <u>The Medical Center</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>April 16/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. George Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Snow Hill, Rural #1 Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Ginnis</u>		ADDRESS <u>Snow Hill, Md</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>William E. Ginnis</u>	
DATE <u>APR 15 59</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

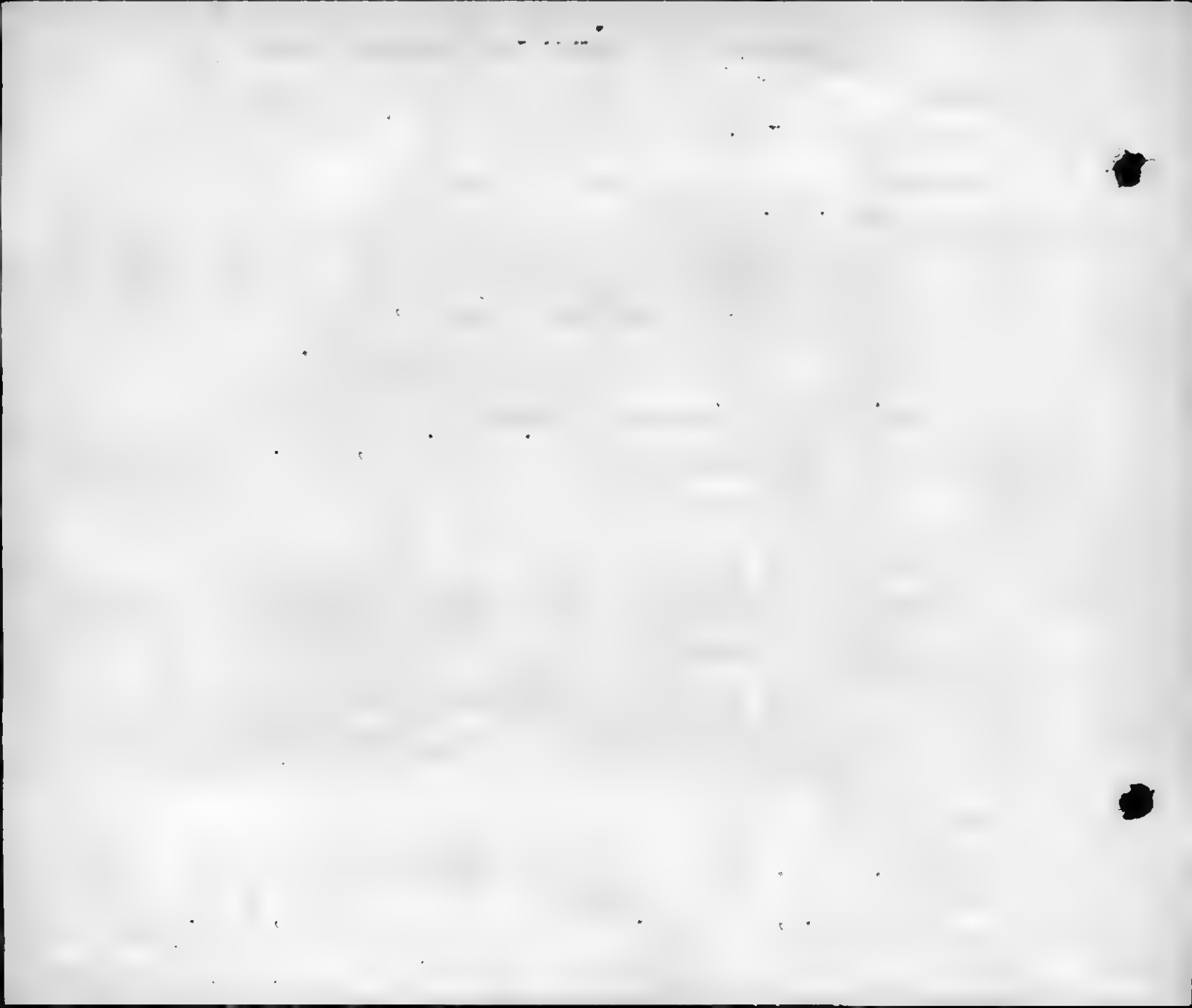
4947 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04942

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mass. b. COUNTY Suffolk	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boston (Brighton)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen.Gen. Hospital		e. STREET ADDRESS 1568 Commonwealth	
3. NAME OF DECEASED (Type or print) First LILLIAN Middle STEWART Last STEWART		4. DATE OF DEATH Month APRIL Day 3rd Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3rd, 1899
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR 0 Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY Unk	
11. BIRTHPLACE (State or foreign country) Everett Mass.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Edward A. Galley		14. MOTHER'S MAIDEN NAME Jeannette Proctor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Leon A. Galley (Brother) #70 Neponset Ave	
17. INFORMANT Dorchester, Mass.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage DUE TO 822x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient with car off road & turned over	
20c. TIME OF INJURY Month, Day, Year 8:00 a.m. 3-23 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury		20f. (City or town) Winnon (County) Winnon (State) Ind	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 3 / 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 7, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		22d. LOCATION (City, town, or county) Boston, Mass. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY * SALISBURY MARYLAND		24a. REC'D BY REGISTRAR APR 9 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Paul S. Frank	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is anticipated, the certificate should be submitted to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial receipt or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4948

CERTIFICATE OF DEATH

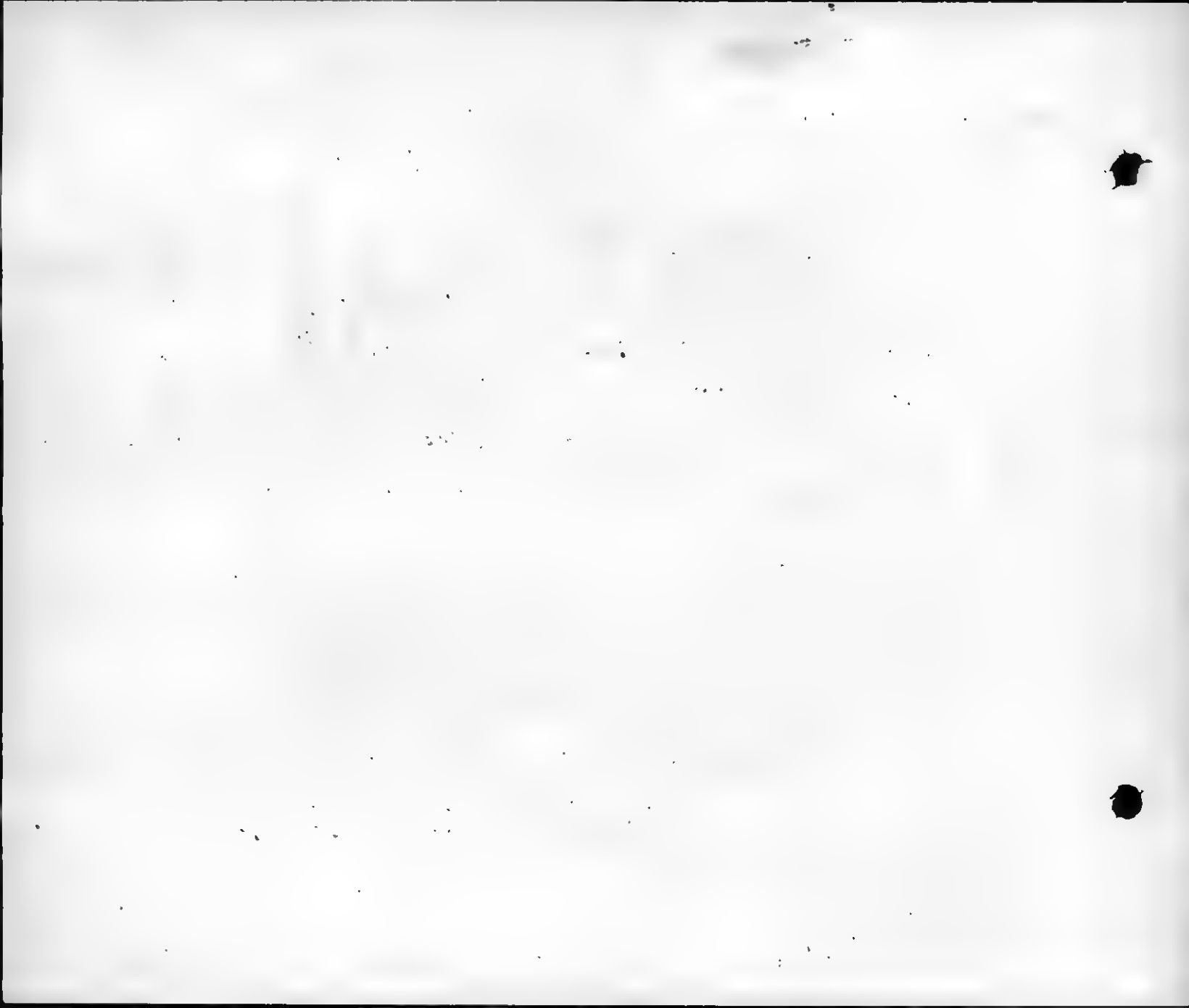
04943
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY in 1b <u>2 WEEKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERMAN F. STINE</u>				4. DATE OF DEATH Month Day Year <u>APRIL 2 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 21-1900</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafood</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM STINE</u>				14. MOTHER'S MAIDEN NAME <u>MARY V. PARKINSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-17-2259</u>		INFORMANT Address <u>Priscilla Stine - Wenona Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 521.1 IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Pulmonary Emphysema</u> (c) <u>Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>3-21</u> , 19 <u>59</u> , to <u>4-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-2</u> , 19 <u>59</u> , and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William A. Ellis</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>4-2-59</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 5-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Methodist</u>	22d. LOCATION (City, town, or county) <u>Wenona Md.</u>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. B. Webster</u> ADDRESS <u>Seaford Md.</u>			24a. REC'D BY REGISTRAR DATE <u>APR 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hane</u>			

Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

VS AIS (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4949 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

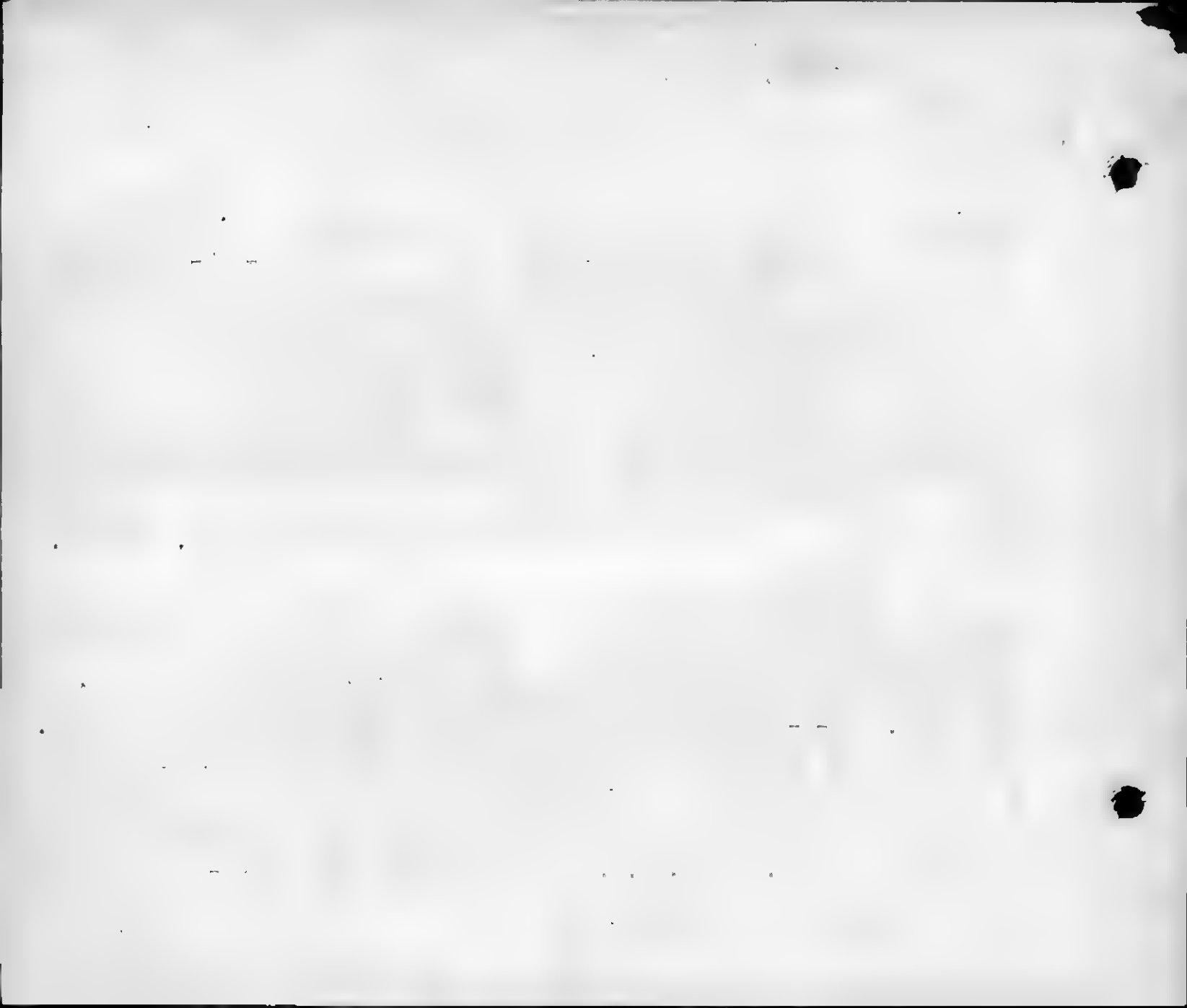
04944

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 10 Months			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 521 Race St.				d. STREET ADDRESS 521 Race St.			
3. NAME OF DECEASED (Type or print) Hilda Lee First Stoin Middle Stone Last Stone				4. DATE OF DEATH 4-7-1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1-1931		9. AGE (In years last birthday) 27 7/8	IF UNDER 1 YEAR: Months 7 Days 7 Hours 15 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Newark, Md	
13. FATHER'S NAME Herbert J. Marshall				14. MOTHER'S MAIDEN NAME Frances Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, and dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT William H. Stone Jr., Winona, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Third degree burns of 100 % body surface. Sudden. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Went to aid of mother in law when fire broke out.			
20c. TIME OF INJURY Month, Day, Year 1 Hour 4-7-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Own home		20f. (City or town) (County) (State) Salisbury Wicomico Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4-9-59			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial April 9/59		22b. DATE THEREOF April 9/59		22c. NAME OF CEMETERY OR CREMATORY Bowen Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Newark, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Clayton Dennis				ADDRESS Snow Hill, Md		24a. REC'D BY REGISTRAR APR 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G241 4-21-51 et

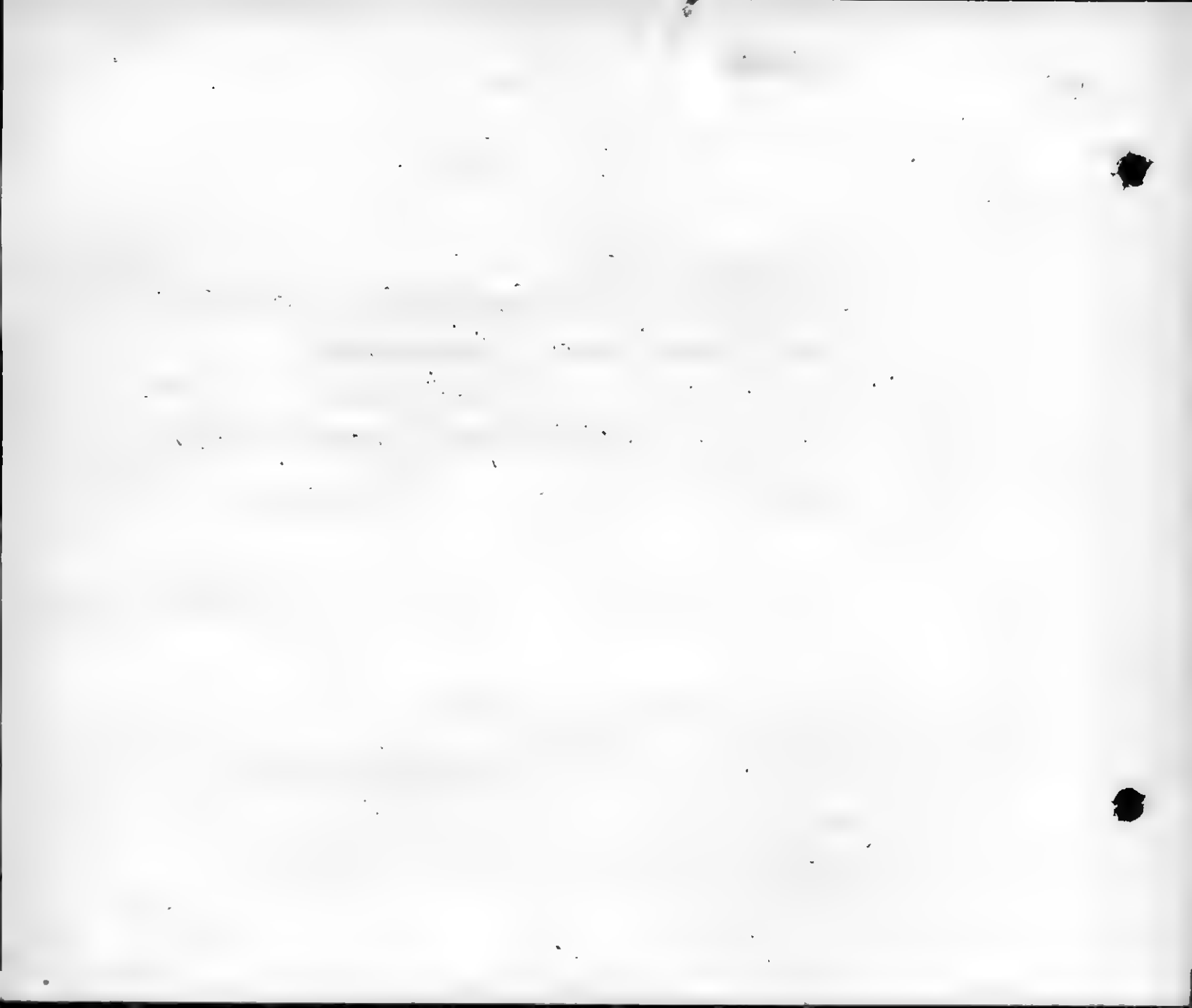
4950

CERTIFICATE OF DEATH

04945

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>1 Day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BRANTHURM Mardela</u>	
		f. STREET ADDRESS <u>-----</u>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Waldo</u> Middle <u>Taylor</u> Last		4. DATE OF DEATH Month <u>APRIL</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/2/1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Taylor</u>		14. MOTHER'S MARDEN NAME <u>Ridella Covington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name and rank) <u>No</u>		16. SOCIAL SECURITY NO <u>218-03-7751</u> INFORMANT Address <u>Virgil Covington, Mardela, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Artery Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 30, 1959</u> to <u>April 2, 1959</u> that I last saw the deceased alive on <u>April 1, 1959</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>May 6, 1959</u>	
PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>		<u>Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Green Hills, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Messick, Bridgeville, Md.</u>		24a. REC'D BY REGISTRAR <u>May 11 1959</u> 24b. REGISTRAR'S SIGNATURE <u>William J. Messick</u>	



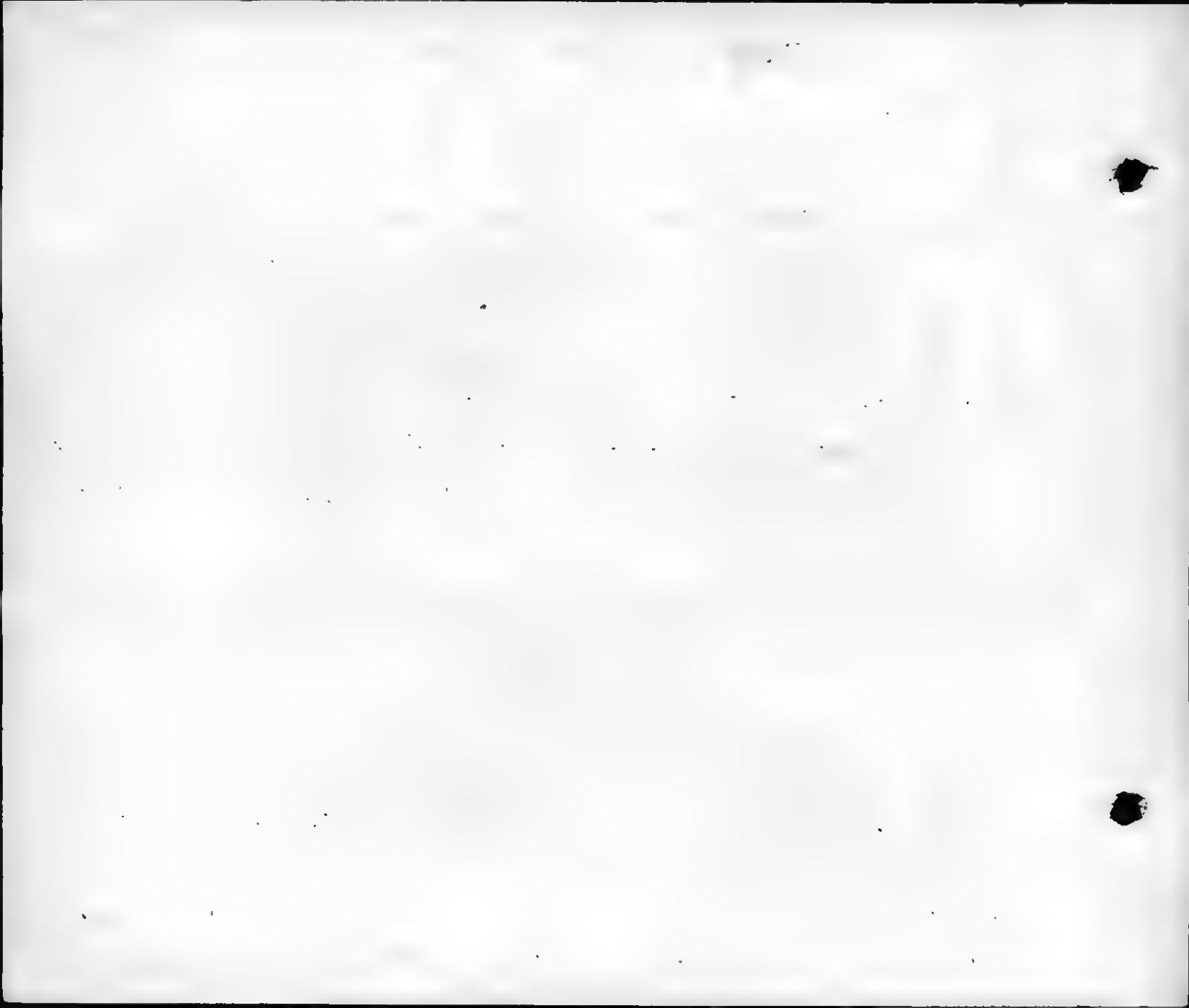
4951

CERTIFICATE OF DEATH

04946

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRANKFORD Del.</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>464 2</u>	
3. NAME OF DECEASED (Type or print) <u>CARSON</u> First <u>Thomas</u> Middle Last		4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/23/1907</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GARDNER THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>HATTIE L. HUDSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>221-22-3655</u>	
17. INFORMANT <u>ELIZABETH THOMAS FRANKFORD DEL.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>circumstances surrounding marriage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William O. Ellis</u> M.D. <u>4-21-59</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Redmens, Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>DAGSBORO DEL.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson & Gray</u>		ADDRESS <u>Frankford Del.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

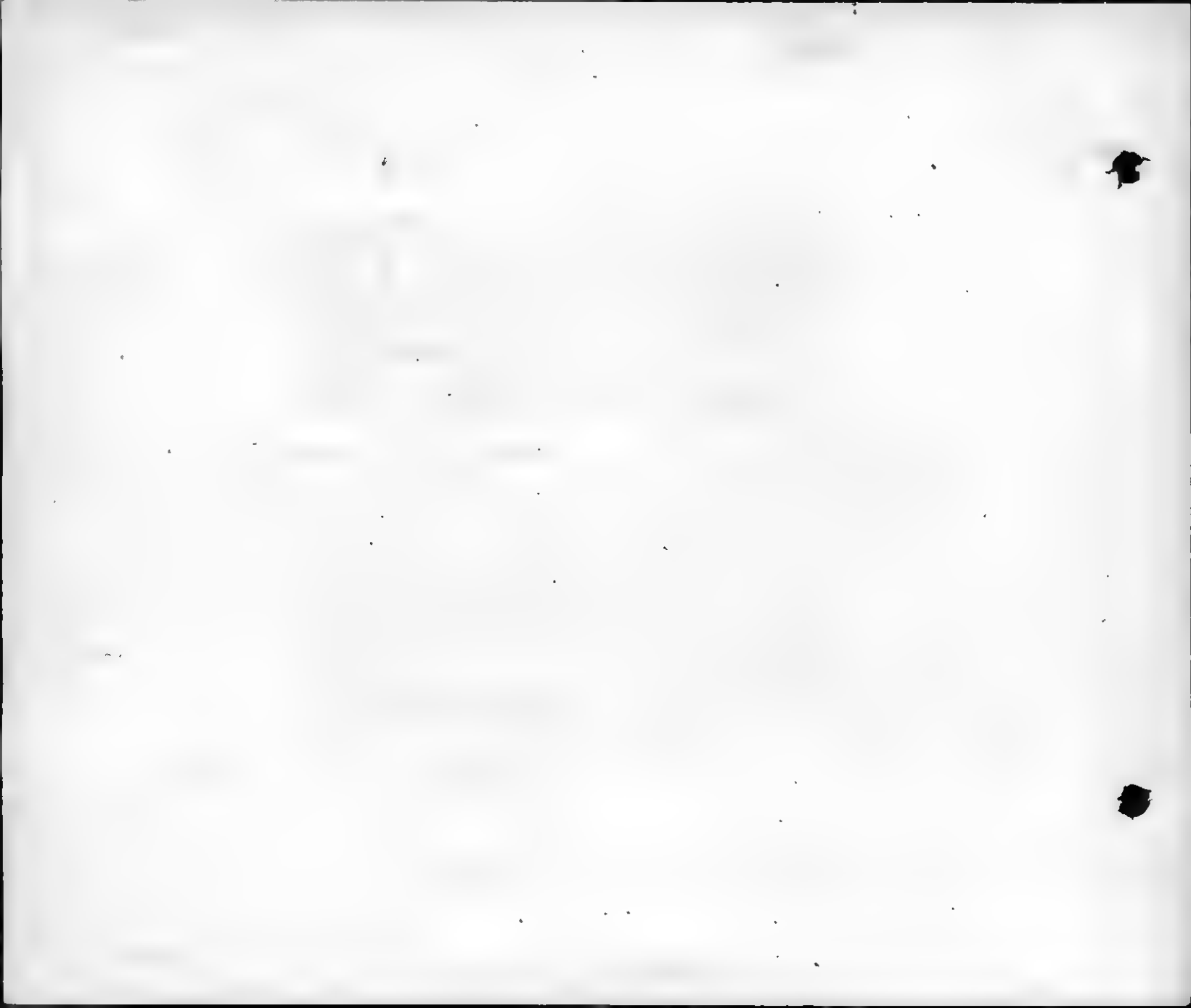
1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4952 Item 2, sec. 1, art. cert.
CERTIFICATE OF DEATH
Items 3, 8, 14 - 11-14-59 et

04947

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland/Virginia</u> b. COUNTY <u>Wicomico</u> <u>Accomack</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury/ Horntown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL GENERAL Hospital</u>		d. STREET ADDRESS <u>32-3</u>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Whitney</u> Middle <u>Townsend</u> Last		4. DATE OF DEATH <u>April</u> Month <u>4</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1959</u>
9. AGE (In years last birthday) yrs <u>5</u>		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Townsend</u>		14. MOTHER'S MAIDEN NAME <u>Sally Pitts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>James Townsend</u>		Address <u>Horntown, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, sec 4</u> <u>7620</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral Anoxia due to</u> (c) <u>Intrauterine Anoxia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>12 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Heinrich Rohls</u> M D		ADDRESS (Street, city or town, state) <u>Berlin, Md.</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Horntown, Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Horntown, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u>		ADDRESS <u>New Church, Va.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Head</u>	

2082261XV4



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4953 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04948

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Md.</u> c. LENGTH OF STAY IN 1b <u>16 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Line 2nd St. Salisbury Md.</u>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Delaware</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Delaware</u> d. STREET ADDRESS <u>1d</u>		
3. NAME OF DECEASED (Type or print) <u>Frank Lee Truitt</u> First Middle Last			4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1959</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>3/17/1926</u>		9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Winos Edward Truitt</u>		
14. MOTHER'S MAIDEN NAME <u>Elsie Mae Dennis</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>222-24-3390</u>			17. INFORMANT <u>Records of Pine Bluff State Hospital</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) <u>Broncho pneumonia</u> DUE TO (b) <u>Pulmonary tuberculosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour <u>19</u> e. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Earl L. Royer</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Earl L. Royer</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cem.</u>	
22d. LOCATION (City, town, or county) (State) <u>Bulow</u> <u>Md.</u>		24a. REC'D BY REGISTRAR <u>DATE APR 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krome</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Aubrey</u> <u>Berlin Md.</u>					



4954

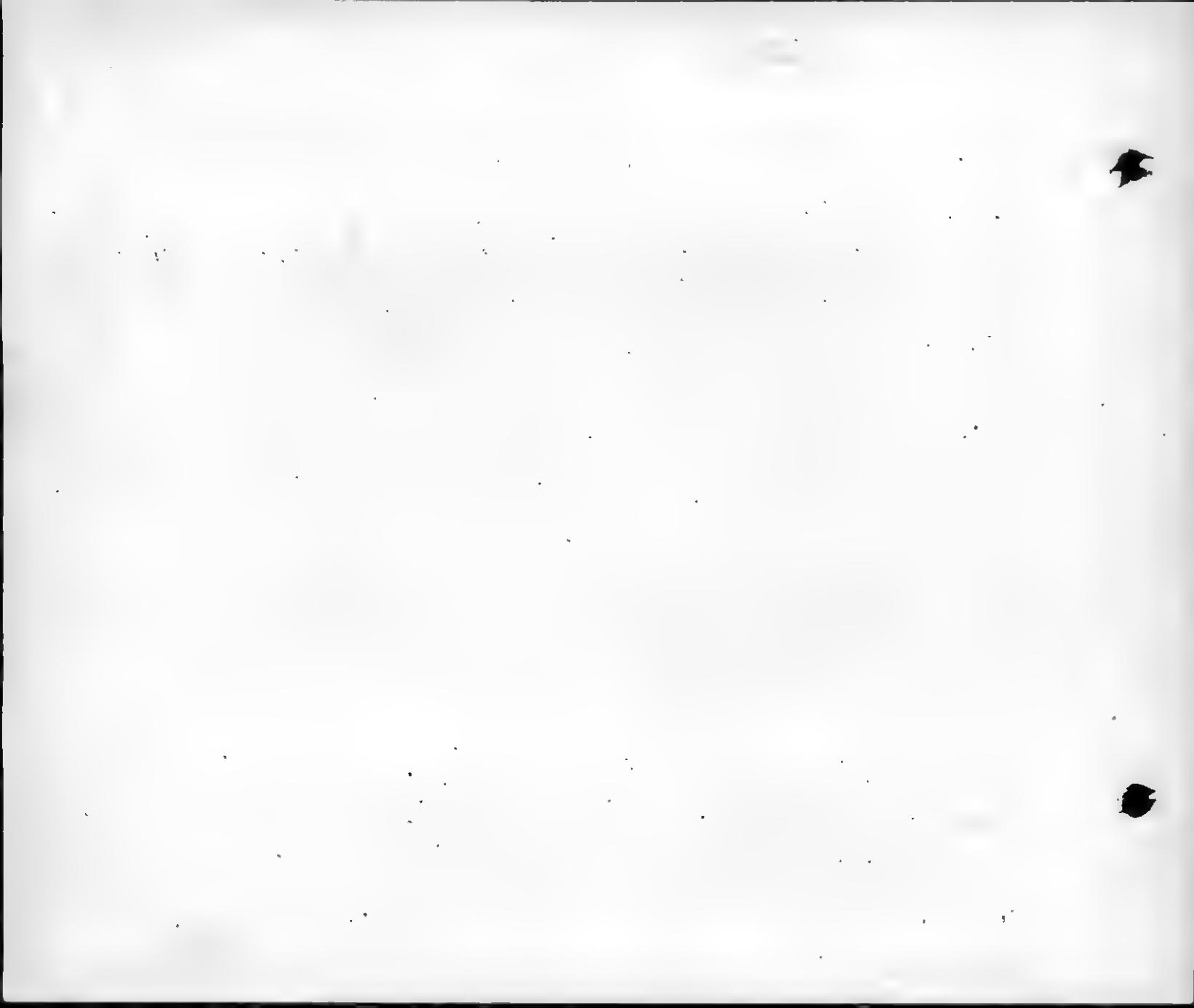
CERTIFICATE OF DEATH

04949

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ARMED & GENERAL Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Vernon Lee Tynes</u>		4. DATE OF DEATH Month Day Year <u>April 14 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 4, 1920</u>
9. AGE (In years Last birthday) yrs <u>38</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>38</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pump tender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar H. Tynes</u>		14. MOTHER'S MAIDEN NAME <u>Isabella Turlington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-16-1557</u>	
17. INFORMANT Address <u>Helia Tynes - Fruitland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory system accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/12</u> , 19 <u>59</u> to <u>4/14</u> , 19 <u>59</u> that I last saw the deceased alive on <u>4/13/59</u> , 19 <u>59</u> , and that death occurred at <u>7 A</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.C. Mitchell</u> M.D.		ADDRESS (Street city or town, state) DATE SIGNED <u>4/14/59</u>	
PHYSICIAN'S NAME (Type) <u>R.C. Mitchell</u>		<u>Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL. (Specify) <u>Remo-Burial 4-10-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Exmore, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Edgar Thomas</u>		ADDRESS <u>Accomac, Va.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. The law may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4955

CERTIFICATE OF DEATH

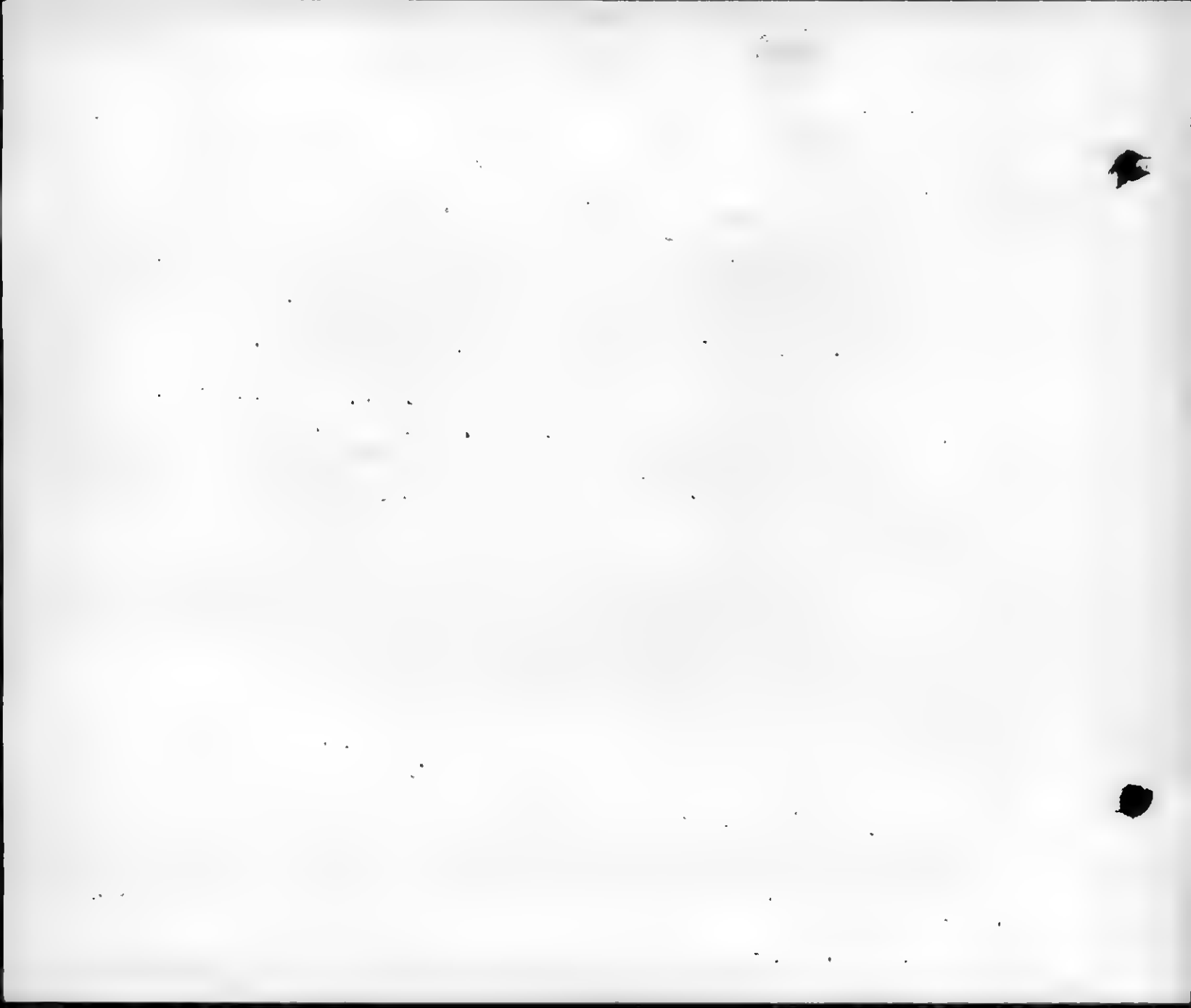
04950

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY, MD		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA General Hospital		e. STREET ADDRESS PHILADELPHIA AVE					
3. NAME OF DECEASED (Type or print)		First WILLIAM FRANK Middle TYRE Last TYRE		4. DATE OF DEATH Month APRIL Day 27 Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 2, 1879	
9. AGE (In years lost birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days 50 Hours 50 Min. 50		IF UNDER 24 HRS. Months 50 Days 50 Hours 50 Min. 50			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) Wicomico Co. MD		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN TYRE		14. MOTHER'S MAIDEN NAME ELIZABETH WILLIAMS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. No		INFORMANT Mrs. W. F. Tyre		Address OCEAN CITY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-14- 19 59 to 4-27- 19 59 , that I last saw the deceased alive on 4-27- 19 59 , and that death occurred at 5:45 A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE W. F. Tyre		M.D.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/30/59		22c. NAME OF CEMETERY OR CREMATORY EVERGREEN		22d. LOCATION (City, town, or county) (State) BELVIN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Bruce A. Burbyce		ADDRESS Berlin Md		24a. REC'D BY REGISTRAR DATE MAY 1 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

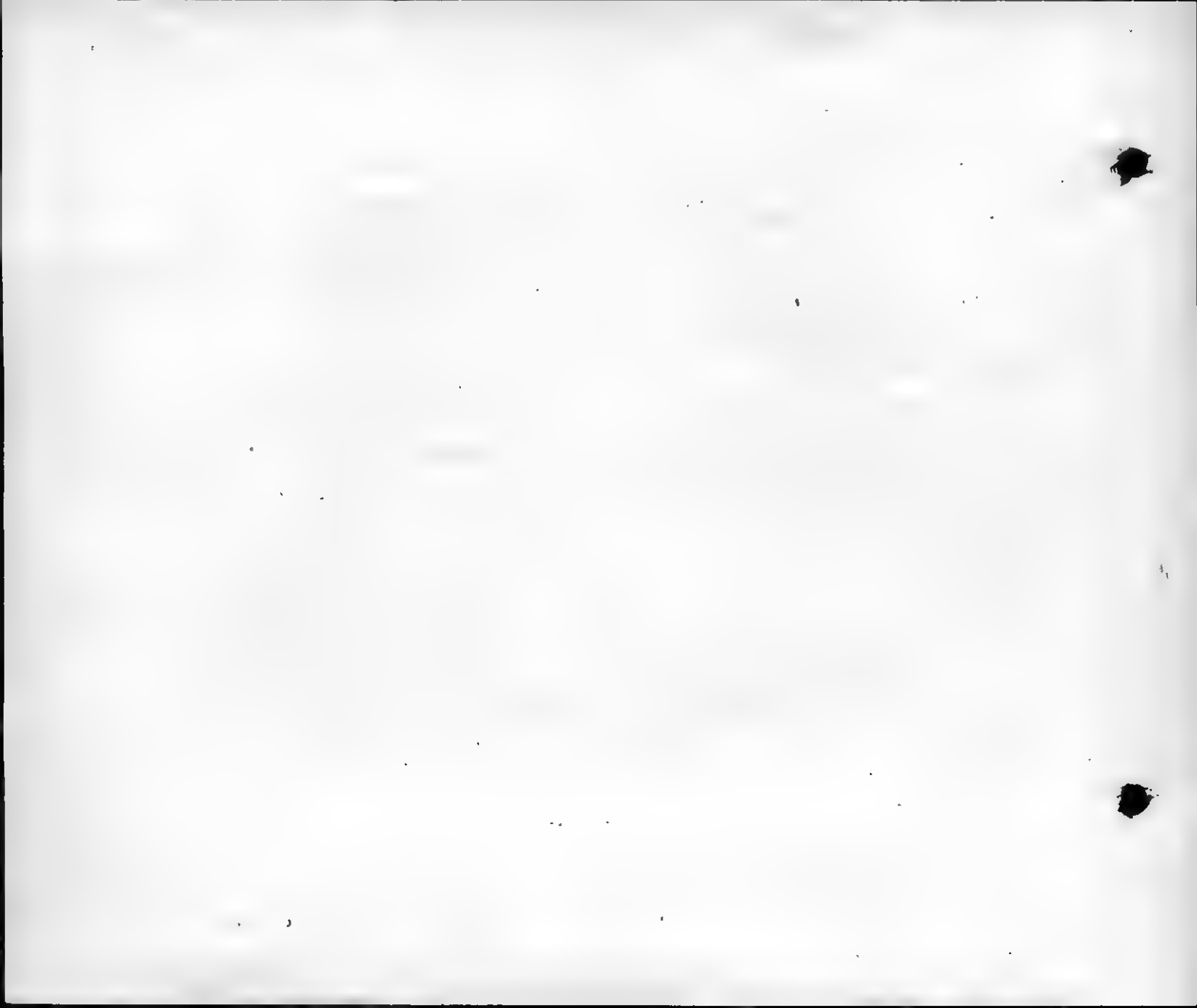


BALTIMORE, 18 4956 Information taken from birth Cert. et CERTIFICATE OF DEATH

04951
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> <u>23x-2</u> d. STREET ADDRESS <u>P. O. Box 202</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Earl Waples</u>		4. DATE OF DEATH Month Day Year <u>APRIL 17 1959</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 15, 1959</u>		9. AGE (In years last birthday) yrs. <u>1</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Harrison Earl Waples</u>						14. MOTHER'S MAIDEN NAME <u>Lois Lorraine Worthington</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>INFORMANT</u> Address <u>Earl Waples Berlin Md.</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birth wt 610 gms)</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 15, 1959</u> to <u>April 17, 1959</u> , that I last saw the deceased alive on <u>April 17, 1959</u> , and that death occurred at <u>4:22 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>August C. Koller</u> M.D. PHYSICIAN'S NAME (Type)															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>4/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>evergreen</u>				22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. Stuart Salisbury Md</u>						24a. REC'D BY REGISTRAR DATE <u>APR 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. Thomas</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4957

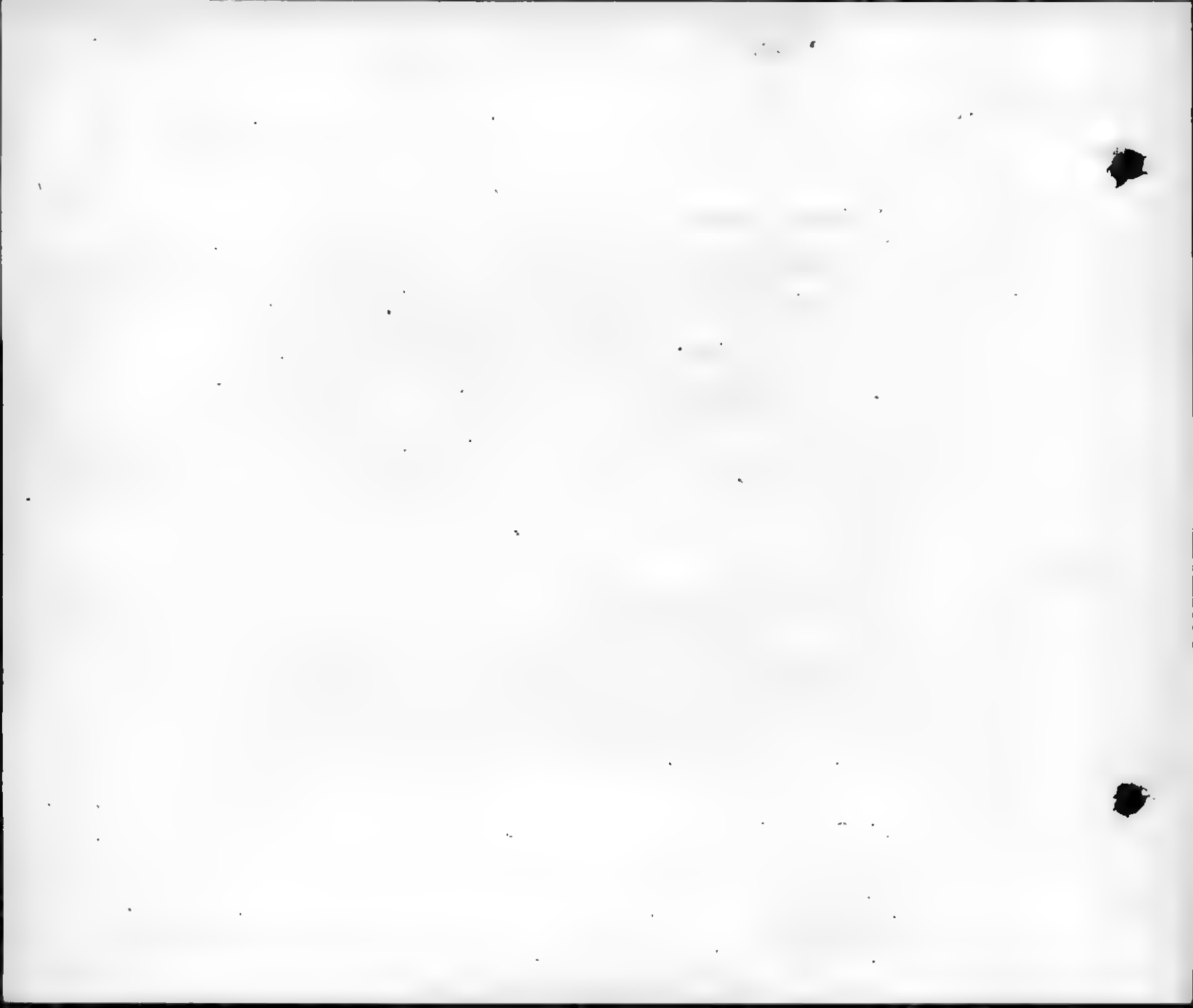
CERTIFICATE OF DEATH

04952

Reg. Dist. No

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>(Ironshire) RFD</u>			
3. NAME OF DECEASED (Type or print) <u>Ernest Warren</u>				4. DATE OF DEATH <u>April 6 - 1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 3, 1892</u>	
9. AGE (In years lost birthday) <u>66</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>SEWELL WARREN</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA HENDERSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>MRS ERNEST WARREN</u>				Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar. 24, 1959</u> to <u>April 6, 1959</u> that I last saw the deceased alive on <u>April 6, 1959</u> and that death occurred at <u>11:20 AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Schumacher</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md April 5, 1959</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>David J. Schumacher</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arne A. Burboys</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>APR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hahn</u>	

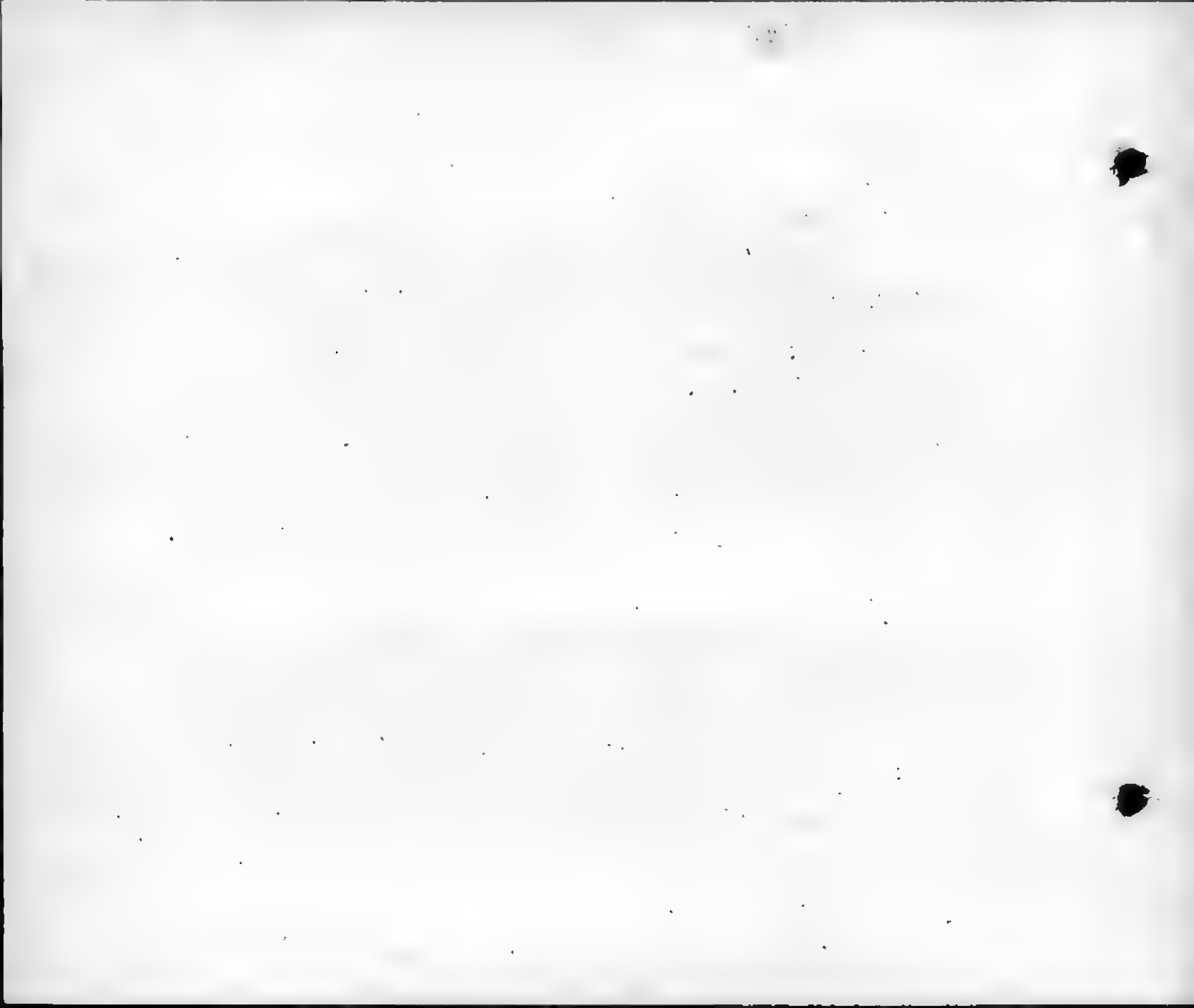


Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4958 CERTIFICATE OF DEATH

04953
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ETHEL WARREN</u>				4. DATE OF DEATH Month Day Year <u>April 15 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 8, 1896</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRACTICAL NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE EVANS</u>				14. MOTHER'S MAIDEN NAME <u>MARY BAKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes, give year or dates of service) <u>No</u>		INFORMANT Address <u>MR. LEE WARREN BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>343X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Encephalitis - Cause Undetermined</u> DUE TO (c) <u>6 days</u>							INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 20, 1959</u> , to <u>April 15, 1959</u> , that I last saw the deceased alive on <u>April 15, 1959</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frederic C. Hill, Jr.</u> M.D.		ADDRESS (Street, City or town, state) <u>Pure Bluff Road Salisbury MD</u>		DATE SIGNED <u>4/15/59</u>			
PHYSICIAN'S NAME (Type) <u>Frederic C. Hill</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anne A. BURBAGE</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>APR 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hunt</u>	

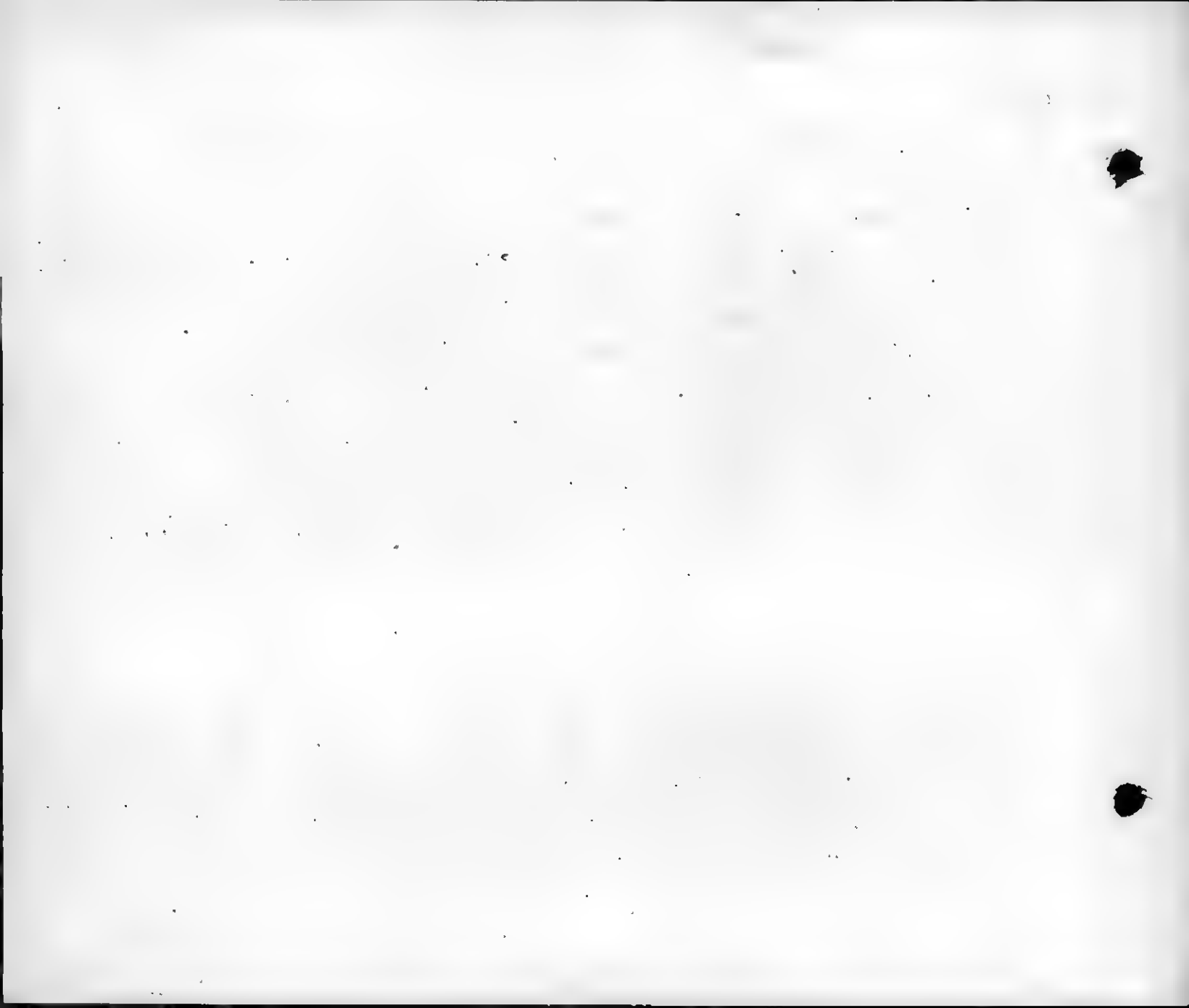


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4959 CERTIFICATE OF DEATH

04954

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEALSBURY</u>		c. LENGTH OF STAY IN 1b <u>17</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Seaside General Hospital</u>		d. STREET ADDRESS <u>MAIN ROAD</u>	
3 NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>E.</u> Last <u>Webster</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9th</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 9-1898</u>
9. AGE (In years last birthday) <u>60</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAFOOD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD PACKER</u>	11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN W WEBSTER</u>	
14. MOTHER'S MAIDEN NAME <u>LOTTIE BENTON</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u> </u>		INFORMANT <u>Edden Webster</u> Address <u>Seal Island Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO (b) <u>Congestive Heart Failure; Arrhythmia</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 das</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebrovascular Accident - 7 das</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/26</u> 19 <u>59</u> to <u>4/9</u> 19 <u>59</u> that I lost saw the deceased alive on <u>4/9</u> 19 <u>59</u> , and that death occurred at <u>5:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner</u> M.D.		ADDRESS (Street, city or town, state) <u>PINEBLUFF Rd. 4/9/59</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>		<u>SALISBURY, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
<u>Burial</u>	<u>April 12, 1959</u>	<u>ST. JOHN'S METH.</u>	<u>Seal Island Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. G. Webster</u> ADDRESS <u>Seal Island Md</u>		24a. REC'D BY REGISTRAR <u>APR 14 59</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Grant</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4960

CERTIFICATE OF DEATH

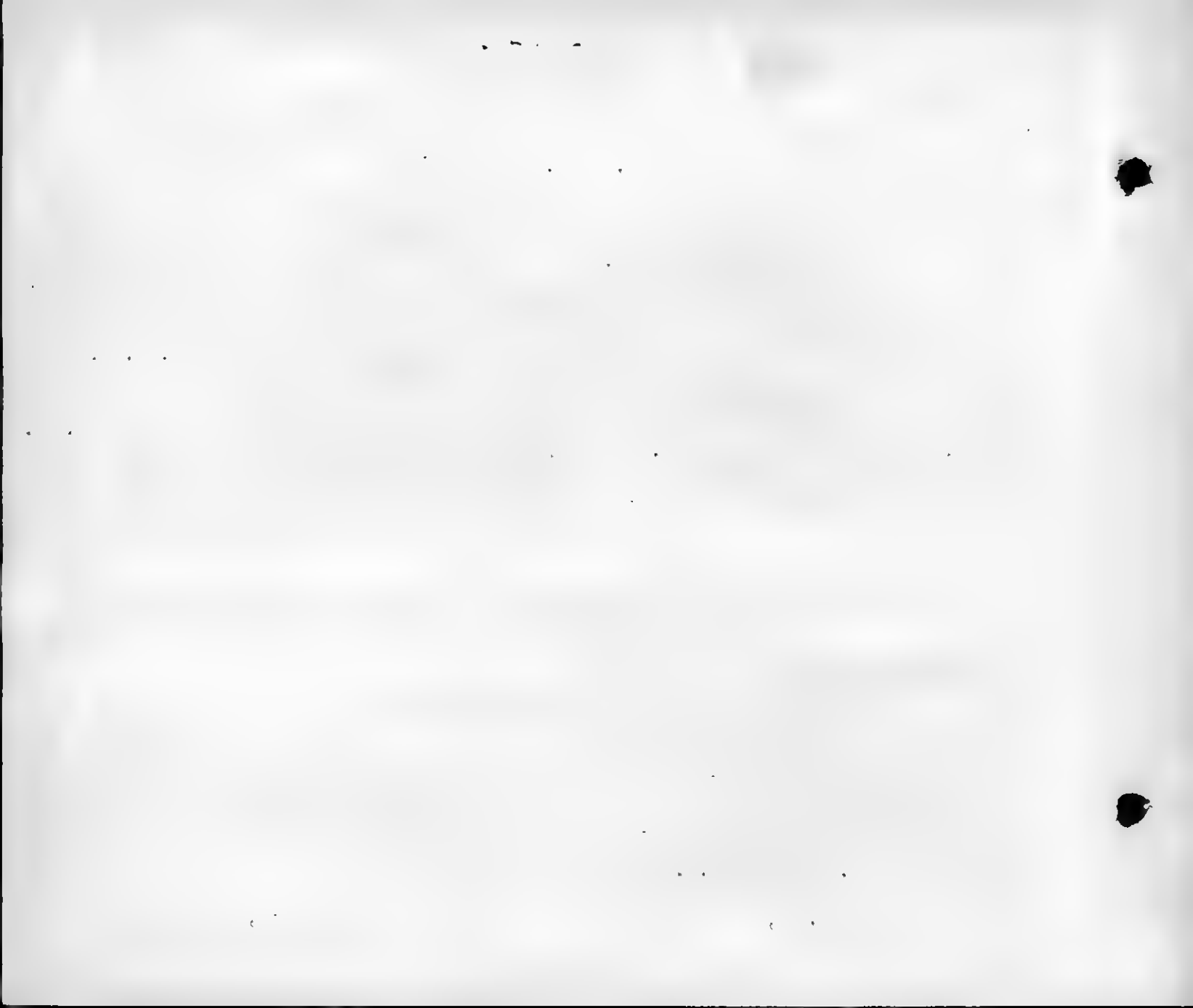
Reg. Dist. No.

04955

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>3 mos. 3 Da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
f. STREET ADDRESS <u>308 Hammond Street</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>M.</u> Last <u>White</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Deceased (Gordon White)</u>		14. MOTHER'S MAIDEN NAME <u>Sarah White Melson Deceased</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO <u>Unk.</u>	
17. INFORMANT <u>Mrs. Marion Hastings (Niece) Sal. Md.</u>		Address <u>Hospital Records -- Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca of Colon</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Anemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/7/59</u> , 19 <u>59</u> , to <u>4/11/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/11/59</u> , 19 <u>59</u> , and that death occurred at <u>1:58A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>4/11/59</u>			
ACTUAL SIGNATURE <u>Dr. V. Juerman</u> M.D.		PHYSICIAN'S NAME (Type) <u>V. Juerman, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 13, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	24a. RECEIVED BY REGISTRAR DATE <u>APR 15 59</u>
		24b. REGISTRAR'S SIGNATURE <u>Conrad A. Thoms</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and sent within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

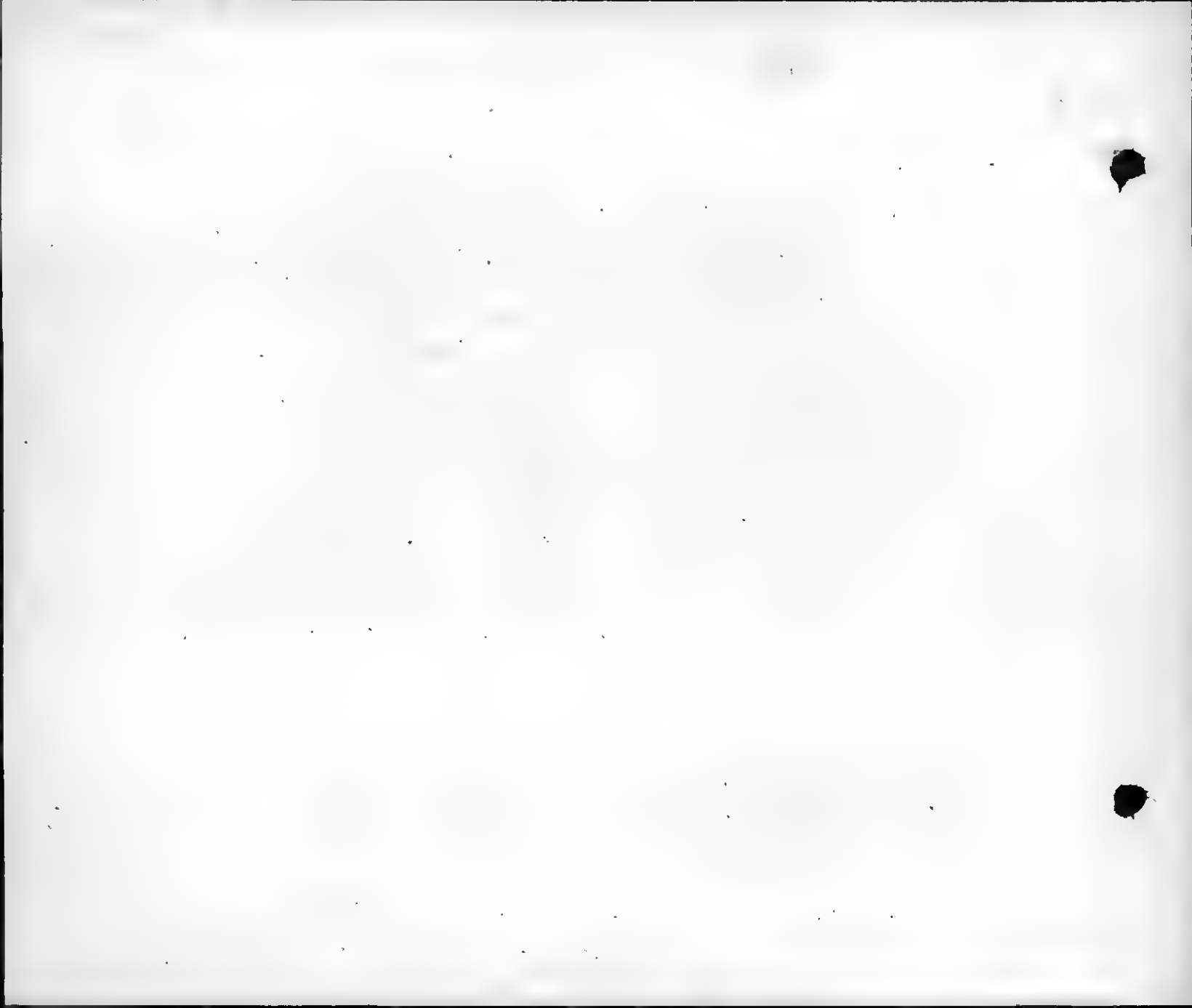
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04956
Reg. Dist. No.

4961

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN lb <u>1 WEEK</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EMERSON GENERAL Hospital</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> d. STREET ADDRESS <u>Ocean City Hwy</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETHEL BEULG WILLIAMS</u>				4. DATE OF DEATH Month Day Year <u>April 8th 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 3, 1911</u>	
9. AGE (In years last birthday) <u>48</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>NEWARK MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JAMES H. WEBB</u>				14. MOTHER'S MAIDEN NAME <u>ROSA BEULG RICHARDS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>MR. OTHO J. WILLIAMS BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ischemic Heart Disease (Coronary Arteriosclerosis & Cardiosclerosis)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1959</u> to <u>April 8, 1959</u> that I last saw the deceased alive on <u>April 7, 1959</u> and that death occurred at <u>6 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Berlin Md</u> DATE SIGNED <u>April 8, 1959</u>							
ACTUAL SIGNATURE <u>[Signature]</u>							
PHYSICIAN'S NAME (Type) <u>[Signature]</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anne D. Gubay</u> ADDRESS <u>Berlin Md.</u>				24a. REC'D BY REGISTRAR <u>APR 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4962

CERTIFICATE OF DEATH

04957
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>	
3. NAME OF DECEASED (Type or print) First <u>WARE</u> Middle <u>TRAVERS</u> Last <u>WILLING</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/14/1902</u>
9. AGE (In years last birthday) <u>56</u>		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oyster packer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood industry</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J. WARE WILLING</u>		14. MOTHER'S MAIDEN NAME <u>STELLA M. TRAVERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Myra Eversman Willing, Nanticoke, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> DUE TO <u>Anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO <u>Essential Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 month</u> (b) <u>3 gm</u> (c) <u>Unknown</u>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Md. 4/25/59</u>	
PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>		<u>Salisbury, Maryland 4/25/59</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/28/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Turners Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Nanticoke, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Persch, Bivalve, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04958

4963

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		d. STREET ADDRESS #23 Gordy Lane (R.D.#5) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELLIE Middle CATHERINE Last WIMBROW		4. DATE OF DEATH Month APRIL Day 9th Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1901
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 5 Days 10 Hours 10 Min.	IF UNDER 24 HRS. Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work at home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) R.D.# Salisbury, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPHUS E. ADKINS		14. MOTHER'S MAIDEN NAME MARY CATHERINE BROWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mr. John M. Wimbrow (Husband) R.D.#5 Gordy Lane (Box #23) Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Pancreatitis 587.0 DUE TO (b) with Secondary Acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Hepatitis		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 8, 1959 to April 9, 1959 that I last saw the deceased alive on April 9, 1959 , and that death occurred at 11:58 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Apr. 10, 1959	
ACTUAL SIGNATURE David J. Gilmore M.D.			
PHYSICIAN'S NAME (Type) Dr. David J. Gilmore		Medical Center - Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 12/1959	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR APR 13 '59 DATE	24b. REGISTRAR'S SIGNATURE Arthur S. House

CERTIFICATE OF DEATH

1902

DECEASED

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Minister

Signature of Undertaker

Signature of Burial

Signature of Interment

Signature of Burial

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04959

4964

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Wisniewski</u> Last <u>Wisniewski</u>		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 22, 1908</u> <u>50</u> yrs.
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Wisniewski</u>		14. MOTHER'S MAIDEN NAME <u>Cywinski</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records, Salisbury, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sq. cell carcinoma of pharynx</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>13 months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 18, 1958</u> , to <u>April 2, 1959</u> , that I last saw the deceased alive on <u>April 2, 1959</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Kosmahly</u>		ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>G. Kosmahly, M. D.</u>		DATE SIGNED <u>4/3/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 7-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Ozazewski</u>		24a. REC'D BY REGISTRAR <u>Eastern Co</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hirsch</u>		DATE <u>APR 6 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BROWN

of County of

City of

Form with multiple lines for text entry, including fields for date, time, and location of death.

Handwritten signature